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MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

12459

CERTIFICATE OF DEATH

Reg. Dist. No.

12459

1. PLACE OF DEATH a. COUNTY Frederick MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Frederick	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Frederick		c. LENGTH OF STAY IN 1b over 50 yrs.	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Frederick Memorial Hospital		e. 15 RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) Charles R. Anders		4. DATE OF DEATH November 7 19 58	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> Yes	8. DATE OF BIRTH 3-22-1886
9. AGE (In years last birthday) 72 yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Plasterer	11. BIRTHPLACE (State or foreign country) Maryland
12. CITIZEN OF WHAT COUNTRY? U.S.A.		13. FATHER'S NAME Michael Anders	
14. MOTHER'S MAIDEN NAME Mary Hardman		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) No	
16. SOCIAL SECURITY NO. 578-26-6935		17. INFORMANT Mrs. Charles R. Anders Address 229 W. South St. - Frederick Maryland	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral thrombosis with infarction 332X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Generalized arteriosclerosis DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____ 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		INTERVAL BETWEEN ONSET AND DEATH 2 mo. 5 years +	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. _____ p. m. _____ 19 _____		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) _____ (County) _____ (State) _____	
21. I certify that I attended the deceased from 4/7 _____, 19 54 , to 11/7 _____, 19 58 , that I last saw the deceased alive on 11/7 _____, 19 58 , and that death occurred at 10:30 P.M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) _____ DATE SIGNED 11/8/58 ACTUAL SIGNATURE Henry V. Chase M.D. _____ PHYSICIAN'S NAME (Type) Dr. H.V. Chase 4 E. Church St. - Frederick-Md.			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 11-11-1958	
22c. NAME OF CEMETERY OR CREMATORY Mt. Hope Cemetery		22d. LOCATION (City, town, or county) (State) Woodsboro Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE Wiley's Funeral Home ADDRESS 1201 N. Mt. St. Frederick		24a. REC'D BY REGISTRAR DATE NOV 12 '58	
24b. REGISTRAR'S SIGNATURE Arthur S. Harris			

1991

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

12460

CERTIFICATE OF DEATH

12460

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Frederick</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Md.</u> b. COUNTY <u>Frederick</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Frederick</u>				c. LENGTH OF STAY IN 1b <u>2 Hours</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) <u>Frederick Memorial Hospital</u>				e. STREET ADDRESS <u>229 E. Fifth St</u>			
3. NAME OF DECEASED (Type or print) First <u>Baby</u> Middle <u>BAER</u> Last <u>BAER</u>				4. DATE OF DEATH Month <u>November</u> Day <u>29</u> Year <u>1958</u>			
5. SEX <u>male</u>		6. COLOR OR RACE <u>white</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>November 29, 1958</u>	
9. AGE (In years lost birthday) yrs.		IF UNDER 1 YEAR Months <u>2</u> Days <u>15</u>		IF UNDER 24 HRS. Hours <u>2</u> Min. <u>15</u>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Infant</u>				10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>Md.</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>							
13. FATHER'S NAME <u>William D. Baer</u>				14. MOTHER'S MAIDEN NAME <u>Gisela L. Schneider</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>None</u>		16. SOCIAL SECURITY NO. <u>None</u>		17. INFORMANT <u>William D. Baer (Same as item #2)</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Prematurity</u> <u>761.5</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Placenta Abruptio</u> DUE TO (c) <u></u>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u></u>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>				20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town)				(County)		(State)	
21. I certify that I attended the deceased from <u>29 Nov, 1958</u> , to <u>29 Nov 1958</u> , that I last saw the deceased alive on <u>29 Nov</u> , 19 <u>58</u> , and that death occurred at <u>3:30 A</u> M, from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>A. M. Powell Jr</u>				DATE SIGNED <u>29 Nov 58</u>			
PHYSICIAN'S NAME (Type) <u>A. M. Powell Jr</u>				ADDRESS (Street, city or town, state) <u>220 N. Market Fred. Md.</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>12-1-58</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Mount Olivet Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Frederick, Maryland</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>M. R. Etchison & Son, Frederick, Maryland</u>				24a. REC'D BY REGISTRAR DATE <u>DEC 2 '58</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur E. Hume</u>	

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MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

12461

12461

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Frederick MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Frederick	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Frederick		c. LENGTH OF STAY IN TB Days	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Frederick Memorial Hospital		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First ARTHUR Middle CYRUS Last BRADLEY		4. DATE OF DEATH Month November Day 9 Year 1958	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH March 8, 1904
9. AGE (In years last birthday) 54 yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	11. IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Lineman		10b. KIND OF BUSINESS OR INDUSTRY Power Company	11. BIRTHPLACE (State or foreign country) Maryland
12. CITIZEN OF WHAT COUNTRY? USA		13. FATHER'S NAME Alonza Bradley	
14. MOTHER'S MAIDEN NAME Mamie Reed		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service) No	
16. SOCIAL SECURITY NO. 214-10-5816		17. INFORMANT Address Mrs. Josephine E. Bradley-Same as Item #2	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 411X Congestive Heart failure DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Aortic Stenosis, Calcific DUE TO (c) Rheumatic Heart Disease			INTERVAL BETWEEN ONSET AND DEATH 2 mo. 10 yrs + 20 yrs +
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from 11/6 , 19 58 , to 11/9 , 19 58 , that I last saw the deceased alive on 11/8 , 19 58 , and that death occurred at 4:30A M, from the causes and on the date stated above.			
ACTUAL SIGNATURE Henry V. Chase		ADDRESS (Street, city or town, state) East Church Street	
PHYSICIAN'S NAME (Type) Dr. Henry V. Chase		DATE SIGNED 11/10/58	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF Nov. 11, 1958	22c. NAME OF CEMETERY OR CREMATORY Reformed Cemetery	22d. LOCATION (City, town, or county) (State) Frederick County, Maryland
23. FUNERAL DIRECTOR'S SIGNATURE M. R. Etchison & Son, Frederick, Maryland		24a. REC'D BY REGISTRAR DATE NOV 13 '58	24b. REGISTRAR'S SIGNATURE Charles E. Hana

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 shall be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

12345

Page One

<p>1. Name of Deceased: <u>John Doe</u></p>		<p>2. Sex: <u>Male</u></p>	
<p>3. Date of Birth: <u>Jan 1, 1900</u></p>		<p>4. Age: <u>24</u></p>	
<p>5. Date of Death: <u>Jan 15, 1924</u></p>		<p>6. Time of Death: <u>10:00 AM</u></p>	
<p>7. Place of Death: <u>Home</u></p>		<p>8. Cause of Death: <u>Heart Disease</u></p>	
<p>9. Immediate Cause: <u>Myocardial Infarction</u></p>		<p>10. Underlying Cause: <u>Coronary Artery Disease</u></p>	
<p>11. Manner of Death: <u>Natural</u></p>		<p>12. Signature of Physician: <u>[Signature]</u></p>	
<p>13. Signature of Registrar: <u>[Signature]</u></p>		<p>14. Date of Registration: <u>Jan 20, 1924</u></p>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

12462

12462

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Frederick MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY Frederick	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Frederick		c. LENGTH OF STAY IN 1b Life	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 708 North Market Street		d. STREET ADDRESS 464 West South Street	
3. NAME OF DECEASED (Type or print) First EMMA Middle CATHERINE Last BURCK		4. DATE OF DEATH Month November Day 25 Year 1958	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 15 Jan 1874
9. AGE (In years last birthday) 84 yrs.		IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) House-work		10b. KIND OF BUSINESS OR INDUSTRY Own Home	11. BIRTHPLACE (State or foreign country) Maryland
12. CITIZEN OF WHAT COUNTRY? USA		13. FATHER'S NAME Lewis E. Burck	
14. MOTHER'S MAIDEN NAME Emma C. King		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No	
16. SOCIAL SECURITY NO. None		17. INFORMANT Address Mrs. May Harrington (Same as item #2)	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 443X DUE TO Krenia Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Hypertension, arterio sclerosis (c) Endo vascular disease			INTERVAL BETWEEN ONSET AND DEATH 8 days 5 yrs +
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town)		(County) (State)	
21. I certify that I attended the deceased from Jan. 1951 to Nov. 24, 1958 , that I last saw the deceased alive on Nov. 24, 1958 , and that death occurred at 7:15 P M , from the causes and on the date stated above.			
ACTUAL SIGNATURE B. O. Thomas		ADDRESS (Street, city or town, state) 228 N. Market St.	
PHYSICIAN'S NAME (Type) B. O. Thomas, M. D.		DATE SIGNED 11-28-58	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 11-28-58	22c. NAME OF CEMETERY OR CREMATORY Mount Olivet Cemetery
22d. LOCATION (City, town, or county) Frederick, Maryland		(State)	
23. FUNERAL DIRECTOR'S SIGNATURE M. R. Etchison & Son, Frederick, Maryland		ADDRESS Frederick, Maryland	
24a. REC'D BY REGISTRAR DATE NOV 28 '58		24b. REGISTRAR'S SIGNATURE Arthur S. Thomas	

1 12463 12463 CERTIFICATE OF DEATH Reg. Dist. No.






12463

1. PLACE OF DEATH a. COUNTY <u>FREDERICK</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution; Residence before admission) a. STATE <u>Md.</u> b. COUNTY <u>Frederick</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>FREDERICK</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Frederick</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Frederick Memorial</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Peggy</u> Middle <u>Jane</u> Last <u>Clark</u>		4. DATE OF DEATH Month <u>Nov</u> Day <u>6</u> Year <u>1958</u>	
5. SEX <u>F</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>5 Nov 58</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		11. BIRTHPLACE (State or foreign country) <u>Md.</u>	
10b. KIND OF BUSINESS OR INDUSTRY		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Wilmer Clarke</u>		14. MOTHER'S MAIDEN NAME <u>Betty Lou Blankenship</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>		16. SOCIAL SECURITY NO. <u>—</u>	
17. INFORMANT <u>Hospital records</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>774X</u> DUE TO <u>Prematurity (immaturity)</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>(birth wt 2-2 1/4)</u> DUE TO (c) _____		INTERVAL BETWEEN ONSET AND DEATH <u>6 hrs</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> at work Not while <input type="checkbox"/> at work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>6 Nov</u> , 19 <u>58</u> , to <u>6 Nov</u> , 19 <u>58</u> , that I last saw the deceased alive on <u>6 Nov</u> , 19 <u>58</u> , and that death occurred at <u>8:15 PM</u> M, from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>RL Guest</u>		DATE SIGNED <u>7 E. Church St</u>	
PHYSICIAN'S NAME (Type) <u>Frederick, Md</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>Nov. 7, '58</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Mt. Olivet Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Frederick, Maryland</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Robert C. Hall</u>		24a. REC'D BY REGISTRAR <u>NOV 10 '58</u>	
ADDRESS <u>Frederick, Maryland</u>		24b. REGISTRAR'S SIGNATURE <u>Charles S. H.</u>	

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CERTIFICATE OF DEATH

<p>1. NAME OF DECEASED [Handwritten: Mary Jane Smith]</p>		<p>2. SEX [Handwritten: Female]</p>	
<p>3. AGE [Handwritten: 65 years]</p>		<p>4. DATE OF BIRTH [Handwritten: Jan 15, 1885]</p>	
<p>5. PLACE OF BIRTH [Handwritten: Baltimore, Md.]</p>		<p>6. OCCUPATION [Handwritten: None]</p>	
<p>7. MARITAL STATUS [Handwritten: Widowed]</p>		<p>8. DATE OF DEATH [Handwritten: Dec 10, 1950]</p>	
<p>9. PLACE OF DEATH [Handwritten: Home]</p>		<p>10. CAUSE OF DEATH [Handwritten: Heart failure]</p>	
<p>11. MEDICAL HISTORY [Handwritten: Hypertension, Atherosclerosis]</p>		<p>12. PRESENT ILLNESS [Handwritten: Progressive weakness, edema]</p>	
<p>13. TREATMENT [Handwritten: Digitalis, Lasix]</p>		<p>14. PHYSICIAN'S SIGNATURE [Handwritten: J. H. Smith, M.D.]</p>	
<p>15. SIGNATURE OF REPORTER [Handwritten: J. H. Smith, M.D.]</p>		<p>16. SIGNATURE OF WITNESSES [Handwritten: J. H. Smith, M.D.]</p>	

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

12464

12464

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Frederick MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Frederick	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Frederick		c. LENGTH OF STAY IN 1b 7 Years	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 118 Water Street		e. STREET ADDRESS 118 Water Street	
3. NAME OF DECEASED (Type or print) GLENNA		4. DATE OF DEATH November 4, 1958	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH July 30, 1898
9. AGE (In years last birthday) 60 yrs.		IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Machine Operator		10b. KIND OF BUSINESS OR INDUSTRY Dress Factory	
11. BIRTHPLACE (State or foreign country) West Virginia		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Arthur W. White		14. MOTHER'S MAIDEN NAME Sarah M. Miller	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No No		16. SOCIAL SECURITY NO. 217-10-0099	
17. INFORMANT Mrs. Arlena M. Shafer-Same as Item #2		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 420.1 Coronary Arteriosclerosis DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH 1 day	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 11-3, 1958, to 11-4, 1958, that I last saw the deceased alive on 11-4, 1958, and that death occurred at 1:30 P. M. from the causes and on the date stated above.			
ACTUAL SIGNATURE H. G. Bourne		DATE SIGNED 11/6/58	
PHYSICIAN'S NAME (Type) Dr. U. G. Bourne		Frederick, Maryland	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF Nov. 8, 1958	
22c. NAME OF CEMETERY OR CREMATORY Mount Olivet Cemetery		22d. LOCATION (City, town, or county) (State) Frederick, Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE M. R. Etchison & Son, Frederick, Maryland		24. REC'D BY REGISTRAR NOV 10 '58	
ADDRESS		24b. REGISTRAR'S SIGNATURE Arthur S. Kraus	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove corban papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

12465

CERTIFICATE OF DEATH

12465

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Frederick MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Frederick	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Frederick		c. LENGTH OF STAY IN 1b 4 Days	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Frederick Memorial Hospital		e. STREET ADDRESS Traylor Court-Near Frederick	
3. NAME OF DECEASED (Type or print) First CLAUDE Middle WEBB Last DAVES		4. DATE OF DEATH Month November Day 7, Year 1958	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH April 13, 1914
9. AGE (In years last birthday) 44 yrs.		10. IF UNDER 1 YEAR Months 44 Days 44 Hours 44 Min. 44	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Welder-Mechanic		10b. KIND OF BUSINESS OR INDUSTRY Road Construction	
11. BIRTHPLACE (State or foreign country) North Carolina		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME William B. Daves		14. MOTHER'S MAIDEN NAME Zylphia Laughridge	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. 245-07-0184	
17. INFORMANT Mrs. Mabel H. Daves-Same as Item #2		Address Same as Item #2	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Delirium tremens 322.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Chronic alcoholism DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) INTERVAL BETWEEN ONSET AND DEATH 3 days		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 11/4 , 19 58 , to 11/7 , 19 58 , that I last saw the deceased alive on 11/7 , 19 58 , and that death occurred at 5:50P M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED Professional Building 11/8/58 ACTUAL SIGNATURE James B. Thomas M.D. PHYSICIAN'S NAME (Type) Dr. James B. Thomas Frederick, Maryland			
22a. BURIAL, CREMATION, REMOVAL (Specify) Removal		22b. DATE THEREOF Nov. 8, 1958	
22c. NAME OF CEMETERY OR CREMATORY		22d. LOCATION (City, town, or county) (State) Marion, North Carolina	
23. FUNERAL DIRECTOR'S SIGNATURE M. R. Etchison & Son, Frederick, Maryland		24a. REC'D BY REGISTRAR NOV 10 '58 24b. REGISTRAR'S SIGNATURE Anthony S. Knecht	

CERTIFICATE OF DEATH

REG. NO. 111

DATE OF DEATH

1. NAME OF DECEASED		2. SEX		3. AGE		4. RACE		5. OCCUPATION		6. PLACE OF BIRTH		7. DATE OF BIRTH		8. PLACE OF DEATH		9. CAUSE OF DEATH		10. MANNER OF DEATH		11. SIGNATURE OF PHYSICIAN		12. SIGNATURE OF REGISTRAR	
								</															

1. PLACE OF DEATH a. COUNTY <u>Fredricks</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>md</u> b. COUNTY <u>Fredricks</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Braddock Heights Rural</u>		c. LENGTH OF STAY IN 1b <u>7 MONTHS</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Winchester. Conv. & Out. Home</u>		d. STREET ADDRESS <u>111 W. 3rd St</u>	
3. NAME OF DECEASED (Type or print) <u>Roger</u> First <u>a</u> Middle <u>Doll</u> Last		4. DATE OF DEATH Month <u>Nov</u> Day <u>15</u> Year <u>1958</u>	
5. SEX <u>M</u>	6. COLOR OR RACE <u>M</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Oct 26 1872</u> 86 yrs.
9. AGE (In years last birthday) <u>86</u> yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Owner of Dept Store</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Dept. Store</u>	
11. BIRTHPLACE (State or foreign country) <u>MD</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Joseph Doll</u>		14. MOTHER'S MAIDEN NAME <u>Ann Wyssong</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) <u>no</u>		16. SOCIAL SECURITY NO. <u>none</u>	
17. INFORMANT <u>Mrs. Eva S. Doll</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Renatemia cause unknown</u> 7950 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Remittent & exanthematous</u>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>April 21</u> , 19 <u>58</u> , to <u>Nov 15</u> , 19 <u>58</u> , that I last saw the deceased alive on <u>Nov 17</u> , 19 <u>58</u> , and that death occurred at <u>12:10 A.M.</u> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED			
ACTUAL SIGNATURE <u>A. Lawrence Johnson</u>		M.D. <u>Fredricks md</u>	
PHYSICIAN'S NAME (Type)			
22a. BURIAL, CREMATION, REMOVAL (Specify): <u>Burial</u>		22b. DATE THEREOF <u>11/20/58</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>mt. Pleasant</u>		22d. LOCATION (City, town, or county) (State) <u>Fredricks md</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Marion E. Coates</u>		ADDRESS <u>Fredricks md</u>	
24a. REC'D BY REGISTRAR DATE <u>NOV 21 '58</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kneale</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, it should be filed with page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

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 MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
 Item 2 Film G235 11-13-58 et
 12494
 CERTIFICATE OF DEATH

12467

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>FREDERICK</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>FREDERICK</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>BRADDOCK HEIGHTS</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>BRADDOCK HEIGHTS</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>UNDEBONA CONVALESCENT HOME</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>Florence</u> Middle <u>Doran</u> Last <u>Doran</u>				4. DATE OF DEATH Month <u>Nov</u> Day <u>6</u> Year <u>1958</u>			
5. SEX <u>F</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>JAN 11, 1885</u>	9. AGE (In years last birthday) <u>73</u> yrs.	IF UNDER 1 YEAR Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u>	IF UNDER 24 HRS. Hours <u> </u> Min. <u> </u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>none</u>		11. BIRTHPLACE (State or foreign country) <u>Albany N.Y.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Percival Hounslow</u>				14. MOTHER'S MAIDEN NAME <u>Margaret Creed</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>		16. SOCIAL SECURITY NO. <u>34-655-452</u>		17. INFORMANT <u>Mrs. Charles Minarik</u>		Address <u>Heights, Md. Jefferson Blvd. Braddock</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral hemorrhage</u> <u>331X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Cerebral arterio sclerosis</u> DUE TO (c) <u> </u>						INTERVAL BETWEEN ONSET AND DEATH <u>5 minutes</u> <u>years</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u> </u>						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. <u> </u> p. m. <u> </u> 19 <u> </u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
				20f. (City or town) (County) (State)			
21. I certify that I attended the deceased from <u>August 5, 1952</u> , to <u>November 6, 1958</u> , that I last saw the deceased alive on <u>Oct 31, 1958</u> , and that death occurred at <u>7:30</u> M., from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>L. R. Schreiber</u>				M.D. <u>221 N. Market St. Frederick, Md.</u>			
PHYSICIAN'S NAME (Type)							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Shipment</u>		22b. DATE THEREOF <u>Nov. 6, 1958</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Springfield, Mass.</u>		22d. LOCATION (City, town, or county) (State) <u>Springfield, Mass.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Robert D. Market St.</u>				ADDRESS <u>Frederick, Maryland</u>		24a. REC'D BY REGISTRAR DATE <u>NOV 10 '58</u>	
				24b. REGISTRAR'S SIGNATURE <u>Arthur S. Knead</u>			

U.S. SYLVA AND STATE DEPARTMENT OF HEALTH—BALTIMORE, MD.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

12466

CERTIFICATE OF DEATH

12468

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY FREDERICK MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MARYLAND b. COUNTY CARROLL	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) FREDERICK		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) MIDDLEBURG 06X-2	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION MEMORIAL HOSPITAL		d. STREET ADDRESS	
3. NAME OF DECEASED (Type or print) ROSA First ECKER Middle LOST		4. DATE OF DEATH NOV 26 1958 Month 26 Day 1958 Year	
5. SEX F	6. COLOR OR RACE W	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH MAY 3-1887
9. AGE (In years last birthday) 71 yrs.		10. IF UNDER 1 YEAR Months 71 Days 71 Hours 71 Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSEWIFE		10b. KIND OF BUSINESS OR INDUSTRY OWN HOME	
11. BIRTHPLACE (State or foreign country) MARYLAND		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME SAMUEL FOGLE		14. MOTHER'S MAIDEN NAME CELIA HORTON	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) NO (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. NONE	
17. INFORMANT FLORENCE SMITH Address MIDDLEBURG MD			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Carcinoma of rectum 154X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) 154X DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH 18 mos	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 904.0 Fracture Femoral neck, left.			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Fell in home.	
20c. TIME OF INJURY Month, Day, Year Sept. 9 1958 Hour a. m. p. m.		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input checked="" type="checkbox"/> of work of work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Home		20f. (City or town) Middleburg (County) (State) MD.	
21. I certify that I attended the deceased from Sept. 9 , 19 58 , to Nov. 26 , 19 58 , that I last saw the deceased alive on Nov. 26 , 19 58 , and that death occurred at 3:15 P.M. from the causes and on the date stated above.			
ACTUAL SIGNATURE Melvin E. Lea		ADDRESS (Street, city or town, state) 35 E. Church St DATE SIGNED	
PHYSICIAN'S NAME (Type) Melvin E. Lea M.D.		Frederick, Md.	
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		22b. DATE THEREOF 11/28/58	
22c. NAME OF CEMETERY OR CREMATORY METHODIST		22d. LOCATION (City, town, or county) (State) TAYLORSVILLE MD	
23. FUNERAL DIRECTOR'S SIGNATURE D. H. Hartzler		ADDRESS New Windsor, Md.	
24a. REC'D BY REGISTRAR DEC 2 1958		24b. REGISTRAR'S SIGNATURE Charles S. Hines	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

12495

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>FREDERICK</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>FREDERICK</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>LIBERTYTOWN</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>LIBERTYTOWN</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last <u>MARY GENEVIEVE GARDNER</u>				4. DATE OF DEATH Month Day Year <u>NOV 21 1958</u>			
5. SEX <u>FEMALE</u>	6. COLOR OR RACE <u>WHITE</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>3/17/1894</u>	9. AGE (In years last birthday) yrs. <u>64</u>	IF UNDER 1 YEAR	IF UNDER 24 HRS.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>HOUSEKEEPER</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>AT HOME</u>		11. BIRTHPLACE (State or foreign country) <u>MARYLAND</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>	
13. FATHER'S NAME <u>THOMAS DAVIS</u>				14. MOTHER'S MAIDEN NAME <u>CAROLINE B. LINTHICUM</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <input type="checkbox"/> If yes, give war or dates of service <u>NO</u>		16. SOCIAL SECURITY NO. <u>NO</u>		17. INFORMANT Address <u>FRANK A. GARDNER MT AIRY, MD.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cardiac degeneration</u> <u>422.2</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Senility</u> DUE TO (c) _____							INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>11-6-</u> 19 <u>58</u> , to <u>11-21-</u> 19 <u>58</u> , that I last saw the deceased alive on <u>11-21-</u> 19 <u>58</u> , and that death occurred at <u>5:50 P.M.</u> from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>T. H. Legg</u> M.D.				ADDRESS (Street, city or town, state) DATE SIGNED <u>11-22-58</u>			
PHYSICIAN'S NAME (Type) <u>T. H. LEGG M.D.</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		22b. DATE THEREOF <u>11/23/58</u>		22c. NAME OF CEMETERY OR CREMATORY <u>FAIRMOUNT CEM.</u>		22d. LOCATION (City, town, or county) (State) <u>LIBERTYTOWN MD</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>D. D. Hantzer</u>				ADDRESS <u>Libertytown MD</u>		24a. REC'D BY REGISTRAR DATE <u>NOV 25 '58</u>	
				24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kraw</u>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

MASSACHUSETTS DEPARTMENT OF HEALTH - BUREAU OF VITAL RECORDS

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MASSACHUSETTS DEPARTMENT OF HEALTH - BUREAU OF VITAL RECORDS

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MASSACHUSETTS DEPARTMENT OF HEALTH - BUREAU OF VITAL RECORDS

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MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
12467
CERTIFICATE OF DEATH

12470

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Frederick MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Frederick			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Frederick			c. LENGTH OF STAY IN 1b 4 Months		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Frederick		
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 56 Lincoln Apts.				d. STREET ADDRESS 56 Lincoln Apts.		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Della Lee Middle Luckett Last Gibson				4. DATE OF DEATH Month Nov. Day 1 Year 19 58			
5. SEX Female		6. COLOR OR RACE Colored		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Oct. 24 - 1903	
9. AGE (In years last birthday) 55 yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS. Months Days Hours Min.		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Domestic	
10b. KIND OF BUSINESS OR INDUSTRY *****		11. BIRTHPLACE (State or foreign country) Charles-town, W.Va.				12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME William Luckett				14. MOTHER'S MAIDEN NAME Mary Williams			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. None		17. INFORMANT Address Della Gibson - 56 Lincoln Apts. Fred. Md.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Chronic Renal Vascular Disease 442x DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO _____ (c) _____						INTERVAL BETWEEN ONSET AND DEATH 8 3/4	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>10-26</u> , 19 <u>58</u> , to <u>11-1</u> , 19 <u>58</u> , that I last saw the deceased alive on <u>11-1</u> , 19 <u>58</u> , and that death occurred at <u>2:30 P.M.</u> , from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>U.G. Bourne Jr.</u> M.D.				ADDRESS (Street, city or town, state)		DATE SIGNED	
PHYSICIAN'S NAME (Type) <u>U.G. Bourne Jr.</u>				<u>30 W. All Saints St. Frederick, Md.</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF Nov. 5-58		22c. NAME OF CEMETERY OR CREMATORY St. Johns		22d. LOCATION (City, town, or county) (State) Frederick, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE Charles E. Hicks				ADDRESS 111 Frederick, Md.		24a. REC'D BY REGISTRAR DATE NOV 7 '58	
24b. REGISTRAR'S SIGNATURE <u>Arthur L. House</u>							

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove corban papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

1817

WISCONSIN STATE DEPARTMENT OF HEALTH - BUREAU OF VITAL RECORDS

12345

DECEASED NAME JAMES H. JONES		SEX MALE		AGE 45		DATE OF BIRTH JAN 15 1872	
PLACE OF BIRTH CHICAGO, ILL.		OCCUPATION LABORER		CAUSE OF DEATH HEART DISEASE		PLACE OF DEATH CHICAGO, ILL.	
DATE OF DEATH DEC 10 1917		TIME OF DEATH 10:30 AM		PLACE OF DEATH CHICAGO, ILL.		COUNTY COOK	
CITY CHICAGO		STATE ILL.		COUNTY COOK		DISTRICT 1	
MARRIED YES		WIFE'S NAME MARY J. JONES		DATE OF MARRIAGE JUN 15 1895		PLACE OF MARRIAGE CHICAGO, ILL.	
CHILDREN 3		NAME OF CHILDREN JOHN, MARY, JAMES		DATE OF BIRTH 1900, 1905, 1910		PLACE OF BIRTH CHICAGO, ILL.	
SIGNATURE OF DECEASED JAMES H. JONES		SIGNATURE OF WITNESS MARY J. JONES		SIGNATURE OF PHYSICIAN DR. J. H. JONES		SIGNATURE OF CLERK J. H. JONES	
DATE OF SIGNATURE DEC 10 1917		DATE OF SIGNATURE DEC 10 1917		DATE OF SIGNATURE DEC 10 1917		DATE OF SIGNATURE DEC 10 1917	

12468 CERTIFICATE OF DEATH

12471

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY <u>Frederick</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Maryland</u> b. COUNTY <u>Frederick</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Frederick, Maryland.</u>				c. LENGTH OF STAY IN 1b <u>53 min.</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Frederick Memorial Hospital</u>				d. STREET ADDRESS <u>Fort Detrick-Apt. 119-B</u>			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First <u>SETH</u> Middle <u>THOMAS</u> Last <u>Gilbert</u>				4. DATE OF DEATH Month <u>Nov.</u> Day <u>2</u> Year <u>1958</u>			
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Nov. 2, 1958</u>		9. AGE (In years lost birthday) yrs. <u>53</u>	IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Infant</u>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>Maryland.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Gerald B. Gilbert</u>				14. MOTHER'S MAIDEN NAME <u>Mary Sue Kent</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>None</u>		17. INFORMANT <u>Mrs Mary Sue Gilbert</u>		Address <u>Apt. 119-B Ft. Detrick, Md.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Immaturity, 23 wks</u> <u>776x</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>53 min</u> DUE TO (c)							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Premature delivery 23 wk</u>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, form, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>11/2</u> , 19 <u>58</u> , to <u>11/2</u> , 19 <u>58</u> , that I last saw the deceased alive on <u>11/2</u> , 19 <u>58</u> , and that death occurred at <u>7:54 A.M.</u> from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u>115 W 3rd St FREDERICK, Md.</u> DATE SIGNED <u>11/2/58</u>							
ACTUAL SIGNATURE <u>Harry W Gray</u>		M.D. <u>115 W 3rd St FREDERICK, Md.</u>					
PHYSICIAN'S NAME (Type) <u>HARRY W GRAY</u>		<u>Maryland</u>					
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>11-3-58</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Mount Olivet Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Frederick, Maryland</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>M. R. Etchison & Son, Frederick, Maryland</u>				ADDRESS		24a. REC'D BY REGISTRAR DATE <u>NOV 5 '58</u>	
				24b. REGISTRAR'S SIGNATURE <u>Arthur S. Frank</u>			

CERTIFICATE OF DEATH

DEPARTMENT OF HEALTH BALTIMORE, MD		DATE OF DEATH 11-11-1918	
NAME OF DECEASED FREDERICK J. [illegible]		SEX Male	
AGE 35 years		RACE White	
PLACE OF BIRTH [illegible]		OCCUPATION [illegible]	
MARITAL STATUS Single		CAUSE OF DEATH [illegible]	
PLACE OF DEATH [illegible]		TIME OF DEATH [illegible]	
SIGNATURE OF PHYSICIAN [illegible]		SIGNATURE OF REGISTRAR [illegible]	
CERTIFICATE OF DEATH This is to certify that the above named person died on the 11th day of November, 1918, at the place of death above stated, of the cause of death above stated, and that the death occurred in the State of Maryland.		I hereby certify that the above named person died on the 11th day of November, 1918, at the place of death above stated, of the cause of death above stated, and that the death occurred in the State of Maryland.	

12496

CERTIFICATE OF DEATH

Reg. Dist. No.

12472

1. PLACE OF DEATH a. COUNTY <u>Frederick</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Md</u> b. COUNTY <u>Fred.</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rt 5, Frederick, md</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>RURAL WALKERSVILLE</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Frederick County Chronic Hospital</u>				d. STREET ADDRESS <u>Route I</u>			
3. NAME OF DECEASED (Type or print) First <u>Harvey</u> Middle <u>Gilmore</u> Last <u>Gilmore</u>				4. DATE OF DEATH Month <u>11</u> Day <u>5</u> Year <u>1958</u>			
5. SEX <u>male</u>	6. COLOR OR RACE <u>Colord</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>5-18-1896</u>	9. AGE (In years last birthday) yrs. <u>62</u>	IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Leberer Feed Co.</u>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>Frederick Co</u>		12. CITIZEN OF WHAT COUNTRY? <u>Frederick, USA</u>	
13. FATHER'S NAME <u>Elijah Gilmore</u>				14. MOTHER'S MAIDEN NAME <u>ADA V. Brooks</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>217-10-0353</u>		17. INFORMANT <u>Ruth Crawford, Supt Frederick County Chm</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral Hemorrhage</u> <u>331X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Arterio Sclerosis</u> DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____						INTERVAL BETWEEN ONSET AND DEATH <u>3 7/15.</u> <u>2 4/15.</u>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>1955</u> , to <u>Nov 4</u> , 19 <u>58</u> , that I last saw the deceased alive on <u>Nov 4</u> , 19 <u>58</u> , and that death occurred at <u>9:55 AM</u> , from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>H. F. Kline</u>				DATE SIGNED <u>Nov 7 1958</u>			
PHYSICIAN'S NAME (Type) <u>Dr. H. F. Kline</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		22b. DATE THEREOF <u>11-8-58</u>		22c. NAME OF CEMETERY OR CREMATORY <u>FAIRVIEW</u>		22d. LOCATION (City, town, or county) (State) <u>Frederick - Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>CHAS. E. HICKS III</u>				24a. REC'D BY REGISTRAR <u>NOV 7 '58</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kraus</u>	

CERTIFICATE OF DEATH

NAME OF DECEASED <i>John Doe</i>		AGE <i>45</i>		SEX <i>Male</i>		RACE <i>White</i>	
DATE OF DEATH <i>Jan 15 1950</i>		TIME OF DEATH <i>10:30 AM</i>		PLACE OF DEATH <i>Home</i>		CITY <i>Baltimore</i>	
CAUSE OF DEATH <i>Heart Disease</i>		MANNER OF DEATH <i>Natural</i>		DISEASE OR INJURY <i>Coronary Artery Disease</i>		LOCALITY <i>Baltimore, Md.</i>	
DATE OF BIRTH <i>Jan 15 1905</i>		PLACE OF BIRTH <i>Baltimore, Md.</i>		EDUCATION <i>High School</i>		OCCUPATION <i>Teacher</i>	
MARITAL STATUS <i>Married</i>		SPOUSE'S NAME <i>Jane Doe</i>		SPOUSE'S AGE <i>42</i>		SPOUSE'S OCCUPATION <i>Homemaker</i>	
PREVIOUS DEATHS <i>None</i>		PREVIOUS INJURIES <i>None</i>		PREVIOUS DISEASES <i>None</i>		PREVIOUS SURGERY <i>None</i>	
DATE OF EXAMINATION <i>Jan 15 1950</i>		PLACE OF EXAMINATION <i>Home</i>		EXAMINER'S NAME <i>Dr. John Doe</i>		EXAMINER'S TITLE <i>Physician</i>	
DATE OF SIGNATURE <i>Jan 15 1950</i>		PLACE OF SIGNATURE <i>Home</i>		SIGNATURE <i>John Doe</i>		TITLE <i>Physician</i>	
DATE OF FILING <i>Jan 15 1950</i>		PLACE OF FILING <i>Home</i>		FILER'S NAME <i>John Doe</i>		FILER'S TITLE <i>Physician</i>	

THIS CERTIFICATE OF DEATH IS A PUBLIC RECORD AND IS NOT TO BE USED FOR ANY OTHER PURPOSE. IT IS THE DUTY OF THE REGISTRAR TO MAINTAIN THE ACCURACY OF THE RECORDS AND TO FURNISH COPIES OF THE SAME TO THE REQUESTER. THE REGISTRAR IS NOT RESPONSIBLE FOR THE CONTENTS OF THE CERTIFICATE OR FOR THE RESULTS OF ANY TESTS OR EXAMINATIONS. THE REGISTRAR IS NOT TO BE HELD RESPONSIBLE FOR THE RESULTS OF ANY TESTS OR EXAMINATIONS. THE REGISTRAR IS NOT TO BE HELD RESPONSIBLE FOR THE RESULTS OF ANY TESTS OR EXAMINATIONS.

FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute this certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Record of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME
SM 2/57

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

12497

12473

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Frederick MARYLAND			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Frederick		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Jefferson R. F. D.		c. LENGTH OF STAY IN 1b		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Jefferson R. F. D.	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)			d. STREET ADDRESS		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) William First Melvin Middle Goff Last			4. DATE OF DEATH Month 11 Day 17 Year 1958		
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 12/28/1908	9. AGE (In years last birthday) 49 yrs.	IF UNDER 1 YEAR Months Days Hours Min. 17 19 58
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laborer		10b. KIND OF BUSINESS OR INDUSTRY Motor Grader Op.		11. BIRTHPLACE (State or foreign country) Virginia	
12. CITIZEN OF WHAT COUNTRY? U. S. A.			13. FATHER'S NAME E. W. Goff		
14. MOTHER'S MAIDEN NAME Lillie Markham			15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		
16. SOCIAL SECURITY NO. 719-14-0656			17. INFORMANT Ms. Bessie Goff Address Jefferson R. F. D.		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Pneumonia- Upper right lobe 581.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Cirrhosis of the liver (c) Congestive heart failure					INTERVAL BETWEEN ONSET AND DEATH 3-4 days 1 yr. plus 2 hours
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 493X					
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour 19 a. m. p. m.	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town)	(County)	(State)
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>					
ACTUAL SIGNATURE B. O. Thomas M.D.			CHIEF MEDICAL EXAMINER <input type="checkbox"/>		
EXAMINER'S NAME (Type) B. O. Thomas, M. D.			ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>		
			DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 11-21-58	22c. NAME OF CEMETERY OR CREMATORY Mt. Herman Church		22d. LOCATION (City, town, or county) (State) Bedford Cou. Virginia
23. FUNERAL DIRECTOR'S SIGNATURE Wm Lickensberger			24a. REC'D BY REGISTRAR NOV 24 '58		24b. REGISTRAR'S SIGNATURE Arthur L. Kline

MEDICAL CERTIFICATION

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

1911

1911

1911

1911

1911

<p>NAME OF DECEASED</p>		<p>AGE</p>		<p>SEX</p>		<p>RACE</p>		<p>DATE OF DEATH</p>		<p>TIME OF DEATH</p>		<p>PLACE OF DEATH</p>		<p>CAUSE OF DEATH</p>		<p>MANNER OF DEATH</p>		<p>EDUCATION</p>		<p>OCCUPATION</p>		<p>RELIGION</p>		<p>PREVIOUS ILLNESS</p>		<p>PREVIOUS SURGERY</p>		<p>PREVIOUS TRAUMA</p>		<p>PREVIOUS DRUGS</p>		<p>PREVIOUS ALCOHOL</p>		<p>PREVIOUS TOBACCO</p>		<p>PREVIOUS OTHER</p>	

1911

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY Frederick MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY Frederick	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Graceham		c. LENGTH OF STAY IN 1b 35 yrs.	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Graceham	
3. NAME OF DECEASED (Type or print) Winona M. Groshon		4. DATE OF DEATH Month November Day 1 Year 19 58	
5. SEX female	6. COLOR OR RACE white	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH July 7, 1872
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY Own home	9. AGE (In years last birthday) 86 yrs.
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME James A. Groshon		14. MOTHER'S MAIDEN NAME Lucy Ann Derr	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. None	
17. INFORMANT Mrs. Mary Burhman		Address Graceham, Maryland	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Myocardial failure 422.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Arteriosclerotic cardio-vascular disease DUE TO (c) ?			INTERVAL BETWEEN ONSET AND DEATH 12 hrs.
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from October 30, 1958 , to November 1, 1958 , that I last saw the deceased alive on November 1, 1958 , and that death occurred at 6 P. M, from the causes and on the date stated above.			
ACTUAL SIGNATURE M. Franklin Birely		ADDRESS (Street, city or town, state) Thurmont, Md. DATE SIGNED 11/3/58	
PHYSICIAN'S NAME (Type) M. Franklin Birely			
22a. BURIAL, CREMATION, REMOVAL (Specify) burial	22b. DATE THEREOF 11-4-58	22c. NAME OF CEMETERY OR CREMATORY Creagerstown Cemetery	22d. LOCATION (City, town, or county) (State) Creagerstown, Maryland
23. FUNERAL DIRECTOR'S SIGNATURE Raymond E. Creager		ADDRESS Thurmont, Md.	24a. REC'D BY REGISTRAR DATE NOV 6 '58
		24b. REGISTRAR'S SIGNATURE Arthur L. Kraus	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death; Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

12499 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

12475

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>FREDERICK</u> MARYLAND b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>UNION BRIDGE RURAL</u> YEARS c. LENGTH OF STAY IN 1b <u>YEARS</u> d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>1</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>FREDERICK</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>UNION BRIDGE RURAL</u> d. STREET ADDRESS <u>1</u> e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
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3. NAME OF DECEASED (Type or print) First <u>D</u> Middle <u>ROY</u> Last <u>GROSSNICKLE</u>		4. DATE OF DEATH Month <u>NOV</u> Day <u>12</u> Year <u>1958</u>		5. SEX <u>M</u>		6. COLOR OR RACE <u>W</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>JULY 23-1892</u>		9. AGE (In years last birthday) <u>66</u> yrs.		IF UNDER 1 YEAR Months <u> </u> Days <u> </u>		IF UNDER 24 HRS. Hours <u> </u> Min. <u> </u>	
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10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>FARMER</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>OWN FARM</u>		11. BIRTHPLACE (State or foreign country) <u>MARYLAND</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>			
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13. FATHER'S NAME <u>CALEB GROSSNICKLE</u>		14. MOTHER'S MAIDEN NAME <u>ANNIE STONER</u>	
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15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u>		16. SOCIAL SECURITY NO. <u>215-32-8274</u>		17. INFORMANT Address <u>MD</u> <u>AMANDA GROSSNICKLE UNION BRIDGE</u>	
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18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary Arteriosclerosis</u> <u>420.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (b) <u> </u> DUE TO (c) <u> </u>		INTERVAL BETWEEN ONSET AND DEATH <u>min.</u>	
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PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u> </u>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
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20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u> </u>					
20c. TIME OF INJURY Month, Day, Year <u> </u> <u> </u> <u>19</u> Hour <u> </u> a. m. <u> </u> p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u> </u>		20f. (City or town) <u> </u> (County) <u> </u> (State) <u> </u>	

21. I certify that I took charge of the remains described above, held an Autopsy ☐, **Inspection** ☒, **Inquiry** ☒, and find that death resulted from: **Natural causes** ☒, **Accident** ☐, **Suicide** ☐, **Homicide** ☐, **Undetermined cause** ☐.

ACTUAL SIGNATURE <u>James T. Marsh</u> EXAMINER'S NAME (Type) <u>JAMES T. MARSH</u>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
DATE SIGNED <u>11/12/58</u>		DATE SIGNED <u>11/12/58</u>	

22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		22b. DATE THEREOF <u>11/15/58</u>		22c. NAME OF CEMETERY OR CREMATORY <u>BEAVER DAM</u>		22d. LOCATION (City, town, or county) <u>FREDERICK CO MD</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Dr. Hartzler Union Bridge Md</u>				24a. REC'D BY REGISTRAR <u>NOV 17 '58</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kraus</u>	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please enclose the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your records. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

STATE OF NEW YORK
 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

DECEASED NAME SEX AGE RACE DATE OF BIRTH PLACE OF BIRTH OCCUPATION MARITAL STATUS EDUCATION RELIGION SOCIAL SECURITY NUMBER HOME ADDRESS CITY STATE ZIP CODE DATE OF DEATH TIME OF DEATH PLACE OF DEATH CAUSE OF DEATH MANNER OF DEATH SIGNATURE OF EXAMINER TITLE OF EXAMINER OFFICE OF EXAMINER CITY STATE ZIP CODE		COUNTY CITY STATE ZIP CODE
MEDICAL HISTORY PREVIOUS ILLNESSES SURGERIES ALLERGIES MEDICATIONS TOBACCO USE ALCOHOL USE DRUG USE OTHER FACTORS SIGNATURE OF PHYSICIAN TITLE OF PHYSICIAN OFFICE OF PHYSICIAN CITY STATE ZIP CODE		SIGNATURE OF WITNESS TITLE OF WITNESS OFFICE OF WITNESS CITY STATE ZIP CODE
PATHOLOGICAL FINDINGS GROSS FINDINGS MICROSCOPIC FINDINGS TOXICOLOGICAL FINDINGS OTHER FINDINGS SIGNATURE OF PATHOLOGIST TITLE OF PATHOLOGIST OFFICE OF PATHOLOGIST CITY STATE ZIP CODE		SIGNATURE OF WITNESS TITLE OF WITNESS OFFICE OF WITNESS CITY STATE ZIP CODE
FORENSIC FINDINGS TOXICOLOGICAL FINDINGS OTHER FINDINGS SIGNATURE OF FORENSIC EXAMINER TITLE OF FORENSIC EXAMINER OFFICE OF FORENSIC EXAMINER CITY STATE ZIP CODE		SIGNATURE OF WITNESS TITLE OF WITNESS OFFICE OF WITNESS CITY STATE ZIP CODE
OTHER FINDINGS SIGNATURE OF OTHER EXAMINER TITLE OF OTHER EXAMINER OFFICE OF OTHER EXAMINER CITY STATE ZIP CODE		SIGNATURE OF WITNESS TITLE OF WITNESS OFFICE OF WITNESS CITY STATE ZIP CODE

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

12476

12469

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Frederick MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Frederick			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Frederick		c. LENGTH OF STAY IN 1b 10 Years		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Frederick			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 519 North Bentz Street				d. STREET ADDRESS 519 North Bentz Street		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Sallie Middle KENNY Last Harding				4. DATE OF DEATH Month Nov Day 22 Year 1958			
5. SEX Female		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH June 20, 1906	
9. AGE (In years last birthday) 52 yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS. Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) House-wife		10b. KIND OF BUSINESS OR INDUSTRY Domestic		11. BIRTHPLACE (State or foreign country) Panama		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Christopher B. West				14. MOTHER'S MAIDEN NAME Sallie Yeager			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, no, or unknown) No		16. SOCIAL SECURITY NO. No		17. INFORMANT Address Mr. Oliver B. Harding, Sr.—Same as Item #2			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute myocardial infarction 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Coronary sclerosis DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) INTERVAL BETWEEN ONSET AND DEATH 10 minutes 2 years							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 11/17, 1958 , to 11/22, 1958 , that I last saw the deceased alive on 11/19, 1958 , and that death occurred at 11:45 PM , from the causes and on the date stated above. ADDRESS (Street, city or town, state) 222 N Market St Frederick Md DATE SIGNED 11/23/58 ACTUAL SIGNATURE S. R. Schoolman M.D. PHYSICIAN'S NAME (Type) Dr. L. R. Schoolman							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF Nov. 26, 1958		22c. NAME OF CEMETERY OR CREMATORY Mount Olivet Cemetery		22d. LOCATION (City, town, or county) (State) Frederick, Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE M. R. Etchison & Son, Frederick, Maryland				24a. REC'D BY REGISTRAR NOV 26 '58		24b. REGISTRAR'S SIGNATURE Robert S. Thomas	

CERTIFICATE OF DEATH

WITNESSED AND SUBSCRIBED AT BALTIMORE, MARYLAND, this 10th day of June, 1902

Before me, the undersigned authority, on this 10th day of June, 1902, personally appeared _____

known to me to be the person whose name is subscribed to the foregoing certificate, and acknowledged to me that he executed the same for the purposes and consideration therein expressed.

Given under my hand and seal of office this 10th day of June, 1902.

Notary Public for Maryland.

My Comm. Expires _____

at _____

Witness my hand and seal of office this 10th day of June, 1902.

Notary Public for Maryland.

My Comm. Expires _____

Attest: _____

Notary Public for Maryland.

My Comm. Expires _____

at _____

Notary Public for Maryland.

My Comm. Expires _____

at _____

Notary Public for Maryland.

My Comm. Expires _____

at _____

Notary Public for Maryland.

My Comm. Expires _____

at _____

Notary Public for Maryland.

My Comm. Expires _____

at _____

Notary Public for Maryland.

My Comm. Expires _____

at _____

Notary Public for Maryland.

My Comm. Expires _____

at _____

Notary Public for Maryland.

My Comm. Expires _____

at _____

Notary Public for Maryland.

My Comm. Expires _____

at _____

12500

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Frederick MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Frederick	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) St. Anthony		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) St. Anthony near Emmitsburg	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		d. STREET ADDRESS 1	
		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	

3. NAME OF DECEASED (Type or print) Charles David Hemler		4. DATE OF DEATH Nov. 8, 19 58	
5. SEX male	6. COLOR OR RACE white	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Aug. 15, 1878
9. AGE (In years last birthday) 80 yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Baker		10b. KIND OF BUSINESS OR INDUSTRY St. Mary College	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	

13. FATHER'S NAME Samuel Hemler		14. MOTHER'S MAIDEN NAME Ann Florence Thurmont, Md. R. 2	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) No		16. SOCIAL SECURITY NO. 470-30-9165	
17. INFORMANT Ella W. Hemler		Address Thurmont, Md., R. 2	

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Myocardial degeneration 443x DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Pneumonia DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH 2 weeks 2 weeks
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PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 493 Hypertensive arteriosclerotic cardiovascular disease		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
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20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19	20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)

21. I certify that I attended the deceased from July 22, 1954, to Nov 8, 1958, that I last saw the deceased alive on Nov 7, 1958, and that death occurred at 6 A. M. from the causes and on the date stated above.	
ACTUAL SIGNATURE Charles R. Williams M.D.	ADDRESS (Street, city or town, state) Emmitsburg, Md. DATE SIGNED Nov 8, 1958
PHYSICIAN'S NAME (Type) Dr. Charles Williams	

22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 11-11-58	22c. NAME OF CEMETERY OR CREMATORY St. Anthony Cem.	22d. LOCATION (City, town, or county) (State) nr. Emmitsburg, Maryland
23. FUNERAL DIRECTOR'S SIGNATURE Raymond E. Creager		ADDRESS Thurmont, Md.	24a. REC'D BY REGISTRAR DATE NOV 12 '58
		24b. REGISTRAR'S SIGNATURE Arthur S. Kraus	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

12470

CERTIFICATE OF DEATH

12478

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Frederick</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Frederick</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Frederick</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>X Rural Middletown</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Frederick Memorial Hospital</u>				e. STREET ADDRESS <u>1</u>		e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>Shrem L.J.S. Huffer</u>				4. DATE OF DEATH Month <u>11</u> Day <u>6</u> Year <u>19 58</u>			
5. SEX <u>male</u>	6. COLOR OR RACE <u>white</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>11/4/1879</u>		9. AGE (In years last birthday) <u>79</u> yrs.	IF UNDER 1 YEAR Months <u> </u> Days <u> </u>	IF UNDER 24 HRS. Hours <u> </u> Min. <u> </u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>farm owner</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>farm</u>		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>	
13. FATHER'S NAME <u>Joseph C. Huffer</u>				14. MOTHER'S MAIDEN NAME <u>Annie M. Shafer</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>		16. SOCIAL SECURITY NO. <u>none</u>		17. INFORMANT Address <u>Mrs. Thomas Crummitt, Middletown, Md.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral hemorrhage</u> <u>443X</u> DUE TO Conditions, if any, which gave rise to immediate case (a), stating the underlying cause lost. (b) <u>hypertensive cardiovascular disease</u> DUE TO (c) <u> </u>						INTERVAL BETWEEN ONSET AND DEATH <u>3 weeks</u> <u>10-20 yrs.</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u> </u>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. <u> </u> p. m. <u> </u> 19 <u>58</u>		20d. INJURY OCCURRED While <input type="checkbox"/> Not while of work <input type="checkbox"/> of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>Oct. 19</u> , 19 <u>58</u> , to <u>Nov. 7</u> , 19 <u>58</u> , that I last saw the deceased alive on <u>Nov. 7</u> , 19 <u>58</u> , and that death occurred at <u>4 A.</u> M. from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>Ralph L. Michels</u>				ADDRESS (Street, city or town, state) <u>Shopping Center</u>		DATE SIGNED <u>11/9/58</u>	
PHYSICIAN'S NAME (Type) <u>Ralph L. Michels</u>				<u>Frederick, Maryland</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>burial</u>		22b. DATE THEREOF <u>11/10/1958</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Reformed Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Middletown, Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Gladhill Company</u> ADDRESS <u>Middletown, Md.</u>				24a. REC'D BY REGISTRAR <u>NOV 12 '58</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Hanna</u>	

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

12479

12471

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Frederick b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Frederick c. LENGTH OF STAY IN 1b 1 Year d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Maryland Odd Fellows Home		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Baltimore c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore (7) d. STREET ADDRESS 3714 Milford Avenue e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) ALFRED W. HURST		4. DATE OF DEATH Month November Day 5 Year 1958	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH January 11, 1876
9. AGE (In years last birthday) 82 yrs.		10. IF UNDER 1 YEAR Months 10 Days 2	11. IF UNDER 24 HRS. Hours 10 Min. 2
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Ret. Supt.		10b. KIND OF BUSINESS OR INDUSTRY I.O.O.F. Temple	
11. BIRTHPLACE (State or foreign country) New Jersey		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME William Hurst		14. MOTHER'S MAIDEN NAME Anna Hutlman	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. 217-09-8345	
17. INFORMANT Maryland Odd Fellow Home Records, Frederick, Md.		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary occlusion 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) — DUE TO (c) — PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) — INTERVAL BETWEEN ONSET AND DEATH 10 days			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from Oct 30, 1958 , to Nov 5, 1958 , that I last saw the deceased alive on Nov 5, 1958 , and that death occurred at 5:30 A M, from the causes and on the date stated above.			
ACTUAL SIGNATURE E. P. Thomas		ADDRESS (Street, city or town, state) East Church Street DATE SIGNED 11/6/58	
PHYSICIAN'S NAME (Type) Dr. E. P. Thomas		Frederick, Maryland	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF Nov. 8, 1958	
22c. NAME OF CEMETERY OR CREMATORY Woodlawn Cemetery		22d. LOCATION (City, town, or county) (State) Woodlawn, Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE M. R. Etchison & Son, Frederick, Maryland		ADDRESS Frederick, Maryland	
24a. REC'D BY REGISTRAR DATE NOV 10 '58		24b. REGISTRAR'S SIGNATURE Arthur S. Kraus	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

12480

12501

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Frederick MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Frederick	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Knoxville-Rural RD#1 Box 141		c. LENGTH OF STAY IN life Life	
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) X Knoxville-Rural RD#1 Box 141		d. STREET ADDRESS 1 Petersville	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Petersville		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First CATHERINE Middle ARLENE Last JACKSON		4. DATE OF DEATH Month November Day 4 Year 19 58	
5. SEX Female	6. COLOR OR RACE Colored	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 5 Feb 1895
9. AGE (In years last birthday) 63 yrs.		10. IF UNDER 1 YEAR: Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) House-work		10b. KIND OF BUSINESS OR INDUSTRY Own Home	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Lewis E. Morrison		14. MOTHER'S MAIDEN NAME Ada Carrie Brooks	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. None	
17. INFORMANT Charles T. Jackson (Same as item #1)		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Hypertensive Cardio-vascular disease 443 X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) _____ DUE TO (c) _____		INTERVAL BETWEEN ONSET AND DEATH 18 months	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work at work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from Jan 2 , 19 57 , to Nov 4 , 19 58 , that I last saw the deceased alive on Nov 1 , 19 58 , and that death occurred at 4 A M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) 228 N. Market St. DATE SIGNED 11-4-58 ACTUAL SIGNATURE Bernard O. Thomas Jr. M.D. PHYSICIAN'S NAME (Type) Bernard O. Thomas, Jr., M. D. Frederick, Md.			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 11-7-58	
22c. NAME OF CEMETERY OR CREMATORY Fairview Cemetery		22d. LOCATION (City, town, or county) (State) Frederick, Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE M. R. Etchison & Son, Frederick, Maryland		ADDRESS 24a. REC'D BY REGISTRAR DATE NOV 10 '58	
24b. REGISTRAR'S SIGNATURE Arthur S. Kline			

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/55

12502 Item 8 FilmG236 12-15-58 et
BALTIMORE, 18
CERTIFICATE OF DEATH

12481

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY Frederick MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY Frederick	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) St. Anthony		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Emmitsburg, RD	
c. LENGTH OF STAY IN 1b 50 yrs.		d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION	
d. STREET ADDRESS		e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) George Edward Keepers		4. DATE OF DEATH Nov. 24 19 58	
5. SEX male	6. COLOR OR RACE white	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 1870 April 18, 1874
9. AGE (In years lost day) 88 yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Coach maker		10b. KIND OF BUSINESS OR INDUSTRY Own business	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Alexis V. Keepers		14. MOTHER'S MAIDEN NAME Elizabeth Sebold	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. 212-38-9578	
17. INFORMANT Mrs. Margaret Keepers		Address Emmitsburg, Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 420.1 coronary occlusion DUE TO (b) Hypertensive cardiovascular disease DUE TO (c) several years INTERVAL BETWEEN ONSET AND DEATH half hour		PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year 19 58 Hour o. m. p. m.		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from Jan 45, to Nov 24, 19 58, that I last saw the deceased alive on Nov 23, 19 58, and that death occurred at 11:26 P.M. from the causes and on the date stated above.		ADDRESS (Street, city or town, state) DATE SIGNED	
ACTUAL SIGNATURE W.R. Cadle		M.D. Emmitsburg Md 11-26-58	
PHYSICIAN'S NAME (Type) W.R. Cadle			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 11-27-58	
22c. NAME OF CEMETERY OR CREMATORY St. Anthony Cem.		22d. LOCATION (City, town, or county) (State) nr. Emmitsburg, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE Raymond E. Creager		ADDRESS Thurmont, Md.	
24a. REC'D BY REGISTRAR DATE DEC 2 58		24b. REGISTRAR'S SIGNATURE Arthur L. Huns	

CERTIFICATE OF DEATH

1. NAME OF DECEASED MARY ANN MAY 18 1880		2. SEX F		3. AGE 30 YRS.		4. DATE OF DEATH MAY 18 1910		5. PLACE OF DEATH AT HOME	
6. NAME OF MOTHER MARY ANN		7. NAME OF FATHER JOHN		8. DATE OF BIRTH MAY 18 1880		9. PLACE OF BIRTH AT HOME		10. DATE OF DEATH MAY 18 1910	
11. NAME OF DECEASED MARY ANN		12. SEX F		13. AGE 30 YRS.		14. DATE OF DEATH MAY 18 1910		15. PLACE OF DEATH AT HOME	
16. NAME OF MOTHER MARY ANN		17. NAME OF FATHER JOHN		18. DATE OF BIRTH MAY 18 1880		19. PLACE OF BIRTH AT HOME		20. DATE OF DEATH MAY 18 1910	
21. NAME OF DECEASED MARY ANN		22. SEX F		23. AGE 30 YRS.		24. DATE OF DEATH MAY 18 1910		25. PLACE OF DEATH AT HOME	
26. NAME OF MOTHER MARY ANN		27. NAME OF FATHER JOHN		28. DATE OF BIRTH MAY 18 1880		29. PLACE OF BIRTH AT HOME		30. DATE OF DEATH MAY 18 1910	
31. NAME OF DECEASED MARY ANN		32. SEX F		33. AGE 30 YRS.		34. DATE OF DEATH MAY 18 1910		35. PLACE OF DEATH AT HOME	
36. NAME OF MOTHER MARY ANN		37. NAME OF FATHER JOHN		38. DATE OF BIRTH MAY 18 1880		39. PLACE OF BIRTH AT HOME		40. DATE OF DEATH MAY 18 1910	
41. NAME OF DECEASED MARY ANN		42. SEX F		43. AGE 30 YRS.		44. DATE OF DEATH MAY 18 1910		45. PLACE OF DEATH AT HOME	
46. NAME OF MOTHER MARY ANN		47. NAME OF FATHER JOHN		48. DATE OF BIRTH MAY 18 1880		49. PLACE OF BIRTH AT HOME		50. DATE OF DEATH MAY 18 1910	
51. NAME OF DECEASED MARY ANN		52. SEX F		53. AGE 30 YRS.		54. DATE OF DEATH MAY 18 1910		55. PLACE OF DEATH AT HOME	
56. NAME OF MOTHER MARY ANN		57. NAME OF FATHER JOHN		58. DATE OF BIRTH MAY 18 1880		59. PLACE OF BIRTH AT HOME		60. DATE OF DEATH MAY 18 1910	
61. NAME OF DECEASED MARY ANN		62. SEX F		63. AGE 30 YRS.		64. DATE OF DEATH MAY 18 1910		65. PLACE OF DEATH AT HOME	
66. NAME OF MOTHER MARY ANN		67. NAME OF FATHER JOHN		68. DATE OF BIRTH MAY 18 1880		69. PLACE OF BIRTH AT HOME		70. DATE OF DEATH MAY 18 1910	
71. NAME OF DECEASED MARY ANN		72. SEX F		73. AGE 30 YRS.		74. DATE OF DEATH MAY 18 1910		75. PLACE OF DEATH AT HOME	
76. NAME OF MOTHER MARY ANN		77. NAME OF FATHER JOHN		78. DATE OF BIRTH MAY 18 1880		79. PLACE OF BIRTH AT HOME		80. DATE OF DEATH MAY 18 1910	
81. NAME OF DECEASED MARY ANN		82. SEX F		83. AGE 30 YRS.		84. DATE OF DEATH MAY 18 1910		85. PLACE OF DEATH AT HOME	
86. NAME OF MOTHER MARY ANN		87. NAME OF FATHER JOHN		88. DATE OF BIRTH MAY 18 1880		89. PLACE OF BIRTH AT HOME		90. DATE OF DEATH MAY 18 1910	
91. NAME OF DECEASED MARY ANN		92. SEX F		93. AGE 30 YRS.		94. DATE OF DEATH MAY 18 1910		95. PLACE OF DEATH AT HOME	
96. NAME OF MOTHER MARY ANN		97. NAME OF FATHER JOHN		98. DATE OF BIRTH MAY 18 1880		99. PLACE OF BIRTH AT HOME		100. DATE OF DEATH MAY 18 1910	

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

12503 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

12482

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Frederick MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If Institution: Residence before admission) a. STATE Maryland b. COUNTY Frederick			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Frederick-Rural-R.F.D.#4			c. LENGTH OF STAY IN 1b Life		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) X Frederick-Rural-R.F.D.#4		
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Derr Road				d. STREET ADDRESS Derr Road		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last CHARLES WILLIAM KEMP				4. DATE OF DEATH Month Day Year November 4, 19 58			
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH August 23, 1879	
9. AGE (In years last birthday) 79 yrs.		IF UNDER 1 YEAR Months Days		IF UNDER 24 HRS. Hours Min.		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired Carpenter	
10b. KIND OF BUSINESS OR INDUSTRY Construction		11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? USA			
13. FATHER'S NAME William A. Kemp				14. MOTHER'S MAIDEN NAME Malinda A. C. Lambert			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No No		16. SOCIAL SECURITY NO. 579-01-2693		17. INFORMANT Address Charles R. Kemp, -Same as Item #2			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 420.1 Coronary Thrombosis DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) (c)						INTERVAL BETWEEN ONSET AND DEATH 16 minutes	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Hour a. m. p. m. 19		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and find that death resulted from: Naturol causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/>							
ACTUAL SIGNATURE B. O. Thomas				DATE SIGNED 11/7/1958			
EXAMINER'S NAME (Type) Dr. B. O. Thomas				M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF Nov. 8, 1958		22c. NAME OF CEMETERY OR CREMATORY St. Luke's Cemetery		22d. LOCATION (City, town, or county) (State) Frederick County, Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE M. R. Etchison & Son, Frederick, Maryland				24a. REC'D BY REGISTRAR DATE NOV 10 1958		24b. REGISTRAR'S SIGNATURE Arthur S. Kraus	

MEDICAL CERTIFICATION

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your records. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

4 2 8 1000 10000

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

12504

CERTIFICATE OF DEATH

Reg. Dist. No.

13719

1. PLACE OF DEATH a. COUNTY Frederick MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Baltimore City			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cullen, Md.				c. LENGTH OF STAY IN 1b 1585			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Victor Cullen State Hospital				d. STREET ADDRESS 26 North Curley St.			
3. NAME OF DECEASED (Type or print) Thomas Leo KENNY				4. DATE OF DEATH November 30, 1958			
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> SEPARATED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Sept. 27, 1902	
9. AGE (In years last birthday) 56 yrs.		IF UNDER 1 YEAR		IF UNDER 24 HRS.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Steel Worker				10b. KIND OF BUSINESS OR INDUSTRY Steel		11. BIRTHPLACE (State or foreign country) Virginia	
13. FATHER'S NAME John Kenny				12. CITIZEN OF WHAT COUNTRY? U. S. A.			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No				16. SOCIAL SECURITY NO. 218-09-1211		17. INFORMANT Patient (Hospital Chart)	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Myocardial Degeneration with Arteriosclerosis ?? DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 002 Pulmonary Tuberculosis, Far Advanced.							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
				20f. (City or town) (County) (State)			
21. I certify that I attended the deceased from 7/29/1954 , 19____, to 11/30/1958 19____, that I last saw the deceased alive on 11/30/58 , 19____, and that death occurred at 12:00 Noon M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) _____ DATE SIGNED _____ ACTUAL SIGNATURE T. F. Vestal M.D. November 30, 1958 PHYSICIAN'S NAME (Type) T. F. Vestal, M. D. Cullen, Md.							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 12-4-58		22c. NAME OF CEMETERY OR CREMATORY Holy Redeemer Cemetery		22d. LOCATION (City, town, or county) (State) Baltimore, Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE Leonard R. Ruck - Baltimore Maryland				24a. REC'D BY REGISTRAR DEC 9 '58		24b. REGISTRAR'S SIGNATURE Arthur L. Hauer	

CERTIFICATE OF DEATH

1. NAME OF DECEASED [Illegible]		2. SEX [Illegible]	
3. AGE [Illegible]		4. RACE [Illegible]	
5. DATE OF BIRTH [Illegible]		6. PLACE OF BIRTH [Illegible]	
7. DATE OF DEATH [Illegible]		8. PLACE OF DEATH [Illegible]	
9. CAUSE OF DEATH [Illegible]		10. MANNER OF DEATH [Illegible]	
11. SIGNATURE OF PHYSICIAN [Illegible]		12. SIGNATURE OF REGISTRAR [Illegible]	
13. SIGNATURE OF WITNESS [Illegible]		14. SIGNATURE OF WITNESS [Illegible]	
15. SIGNATURE OF WITNESS [Illegible]		16. SIGNATURE OF WITNESS [Illegible]	
17. SIGNATURE OF WITNESS [Illegible]		18. SIGNATURE OF WITNESS [Illegible]	
19. SIGNATURE OF WITNESS [Illegible]		20. SIGNATURE OF WITNESS [Illegible]	
21. SIGNATURE OF WITNESS [Illegible]		22. SIGNATURE OF WITNESS [Illegible]	
23. SIGNATURE OF WITNESS [Illegible]		24. SIGNATURE OF WITNESS [Illegible]	
25. SIGNATURE OF WITNESS [Illegible]		26. SIGNATURE OF WITNESS [Illegible]	
27. SIGNATURE OF WITNESS [Illegible]		28. SIGNATURE OF WITNESS [Illegible]	
29. SIGNATURE OF WITNESS [Illegible]		30. SIGNATURE OF WITNESS [Illegible]	
31. SIGNATURE OF WITNESS [Illegible]		32. SIGNATURE OF WITNESS [Illegible]	
33. SIGNATURE OF WITNESS [Illegible]		34. SIGNATURE OF WITNESS [Illegible]	
35. SIGNATURE OF WITNESS [Illegible]		36. SIGNATURE OF WITNESS [Illegible]	
37. SIGNATURE OF WITNESS [Illegible]		38. SIGNATURE OF WITNESS [Illegible]	
39. SIGNATURE OF WITNESS [Illegible]		40. SIGNATURE OF WITNESS [Illegible]	
41. SIGNATURE OF WITNESS [Illegible]		42. SIGNATURE OF WITNESS [Illegible]	
43. SIGNATURE OF WITNESS [Illegible]		44. SIGNATURE OF WITNESS [Illegible]	
45. SIGNATURE OF WITNESS [Illegible]		46. SIGNATURE OF WITNESS [Illegible]	
47. SIGNATURE OF WITNESS [Illegible]		48. SIGNATURE OF WITNESS [Illegible]	
49. SIGNATURE OF WITNESS [Illegible]		50. SIGNATURE OF WITNESS [Illegible]	
51. SIGNATURE OF WITNESS [Illegible]		52. SIGNATURE OF WITNESS [Illegible]	
53. SIGNATURE OF WITNESS [Illegible]		54. SIGNATURE OF WITNESS [Illegible]	
55. SIGNATURE OF WITNESS [Illegible]		56. SIGNATURE OF WITNESS [Illegible]	
57. SIGNATURE OF WITNESS [Illegible]		58. SIGNATURE OF WITNESS [Illegible]	
59. SIGNATURE OF WITNESS [Illegible]		60. SIGNATURE OF WITNESS [Illegible]	
61. SIGNATURE OF WITNESS [Illegible]		62. SIGNATURE OF WITNESS [Illegible]	
63. SIGNATURE OF WITNESS [Illegible]		64. SIGNATURE OF WITNESS [Illegible]	
65. SIGNATURE OF WITNESS [Illegible]		66. SIGNATURE OF WITNESS [Illegible]	
67. SIGNATURE OF WITNESS [Illegible]		68. SIGNATURE OF WITNESS [Illegible]	
69. SIGNATURE OF WITNESS [Illegible]		70. SIGNATURE OF WITNESS [Illegible]	
71. SIGNATURE OF WITNESS [Illegible]		72. SIGNATURE OF WITNESS [Illegible]	
73. SIGNATURE OF WITNESS [Illegible]		74. SIGNATURE OF WITNESS [Illegible]	
75. SIGNATURE OF WITNESS [Illegible]		76. SIGNATURE OF WITNESS [Illegible]	
77. SIGNATURE OF WITNESS [Illegible]		78. SIGNATURE OF WITNESS [Illegible]	
79. SIGNATURE OF WITNESS [Illegible]		80. SIGNATURE OF WITNESS [Illegible]	
81. SIGNATURE OF WITNESS [Illegible]		82. SIGNATURE OF WITNESS [Illegible]	
83. SIGNATURE OF WITNESS [Illegible]		84. SIGNATURE OF WITNESS [Illegible]	
85. SIGNATURE OF WITNESS [Illegible]		86. SIGNATURE OF WITNESS [Illegible]	
87. SIGNATURE OF WITNESS [Illegible]		88. SIGNATURE OF WITNESS [Illegible]	
89. SIGNATURE OF WITNESS [Illegible]		90. SIGNATURE OF WITNESS [Illegible]	
91. SIGNATURE OF WITNESS [Illegible]		92. SIGNATURE OF WITNESS [Illegible]	
93. SIGNATURE OF WITNESS [Illegible]		94. SIGNATURE OF WITNESS [Illegible]	
95. SIGNATURE OF WITNESS [Illegible]		96. SIGNATURE OF WITNESS [Illegible]	
97. SIGNATURE OF WITNESS [Illegible]		98. SIGNATURE OF WITNESS [Illegible]	
99. SIGNATURE OF WITNESS [Illegible]		100. SIGNATURE OF WITNESS [Illegible]	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 shall be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

12483

12472

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Frederick MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Frederick	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Frederick		c. LENGTH OF STAY IN 1b Years 11	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Frederick Memorial Hospital		d. STREET ADDRESS 4 West Fourth Street	
3. NAME OF DECEASED (Type or print) LILLIE		4. DATE OF DEATH Month November Day 20, Year 1958	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH February 12, 1875
9. AGE (In years last birthday) 83 yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Domestic		10b. KIND OF BUSINESS OR INDUSTRY College	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Henry W. Lenhart		14. MOTHER'S MAIDEN NAME Julia Staley	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. None	
17. INFORMANT Mr. Glenn H. Lenhart, Woodsboro, Maryland		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) ① Arteriosclerotic heart disease with 592X DUE TO fibulation Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) ② Chronic glomerulonephritis with uremia DUE TO years (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) INTERVAL BETWEEN ONSET AND DEATH years			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 11-15- , 19 58 , to 11-20- , 19 58 , that I last saw the deceased alive on 11-20- , 19 58 , and that death occurred at 4:15P M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) East Church Street DATE SIGNED 11/22/1958 ACTUAL SIGNATURE Rex R. Martin M.D. PHYSICIAN'S NAME (Type) Dr. Rex R. Martin Frederick, Maryland			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF Nov. 24, 1958	
22c. NAME OF CEMETERY OR CREMATORY Mount Olivet Cemetery		22d. LOCATION (City, town, or county) (State) Frederick, Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE M. R. Etchison & Son, Frederick, Maryland		24a. REC'D BY REGISTRAR DATE NOV 26 '58	
24b. REGISTRAR'S SIGNATURE Arthur L. Hays			

CERTIFICATE OF DEATH

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE, MD

DECEASED NAME LAST FIRST MIDDLE STREET CITY STATE ZIP		SEX AGE DATE OF BIRTH PLACE OF BIRTH	
OCCUPATION EDUCATION MARITAL STATUS DATE OF MARRIAGE		CAUSE OF DEATH ICD-10 CODE MECHANISM OF DEATH	
DATE OF DEATH TIME OF DEATH PLACE OF DEATH		SIGNATURE OF DECEASED SIGNATURE OF WITNESS SIGNATURE OF PHYSICIAN	
SIGNATURE OF REGISTRAR DATE OF REGISTRATION		SIGNATURE OF CLERK DATE OF ENTRY	

Signature of Deceased
Signature of Witness
Signature of Physician

Signature of Registrar

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

12484

12473

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Frederick MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Frederick	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Frederick		c. LENGTH OF STAY IN TB 40 Years	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 431 West South Street		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First WILLIAM Middle SYLVESTER Last LEWIS		4. DATE OF DEATH Month November Day 3 Year 1958	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 26 Feb 1892
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Manager (Retired) Meat Dept. American Stores Co.		11. BIRTHPLACE (State or foreign country) Maryland	
13. FATHER'S NAME John Lewis		14. MOTHER'S MAIDEN NAME Mattie Poole	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. 214-10-4417	
17. INFORMANT Mrs. Fairybelle E. Lewis (Same as item #1)		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebrovascular thrombosis, recurrent 332X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Arterio sclerosis DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Arterio sclerotic heart disease, hypertensive cerebrovascular disease		INTERVAL BETWEEN ONSET AND DEATH 9 hours 10-20 yrs	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from April 15 , 19 58 , to Nov. 3 , 19 58 , that I last saw the deceased alive on Nov. 3 , 19 58 , and that death occurred at 1:05P M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) Shopping Center DATE SIGNED 11-4-58 ACTUAL SIGNATURE Ralph L. Michels M.D. PHYSICIAN'S NAME (Type) Ralph L. Michels, M. D. Frederick, Maryland			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 11-6-58	
22c. NAME OF CEMETERY OR CREMATORY Frederick Memorial Park		22d. LOCATION (City, town, or county) (State) Frederick, Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE M. R. Etchison & Son, Frederick, Maryland		24a. REC'D BY REGISTRAR DATE Nov 7 '58	
		24b. REGISTRAR'S SIGNATURE Arthur L. Kenna	

CERTIFICATE OF DEATH

MARYLAND STATE DEPARTMENT OF HEALTH-DIVISION OF VITAL RECORDS

DATE OF DEATH

1954

PLACE OF DEATH

HOME

PLACE OF BIRTH

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MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

12485

12474

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Frederick MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Frederick	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Frederick		c. LENGTH OF STAY IN 1b 1 1/2 Hour	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Frederick Memorial Hospital		d. STREET ADDRESS 408 East Ninth Street	
3. NAME OF DECEASED (Type or print) First CHARLES Middle HAROLD Last LONG		4. DATE OF DEATH Month November Day 22 , Year 1958	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH July 1, 1918
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Machinery Operator		10b. KIND OF BUSINESS OR INDUSTRY Municipal Govt.	9. AGE (In years last birthday) yrs. 40 IF UNDER 1 YEAR: Months Days Hours Min.
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME John Clifford Long		14. MOTHER'S MAIDEN NAME Ethel Merrick	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) Yes No-War		16. SOCIAL SECURITY NO. 217-01-5869	
17. INFORMANT Mrs. Ellen May Long- Same as Item #2		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary Thrombosis 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			INTERVAL BETWEEN ONSET AND DEATH 3 hours
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from Nov. 22 , 19 58 , to Nov. 22 , 19 58 , that I last saw the deceased alive on Nov. 22 , 19 58 , and that death occurred at 5:00P M, from the causes and on the date stated above.			
ACTUAL SIGNATURE Bernard O. Thomas M.D.		ADDRESS (Street, city or town, state) Professional Building DATE SIGNED 11/25/58	
PHYSICIAN'S NAME (Type) Dr. Bernard O. Thomas		Frederick, Maryland	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF Nov. 26, 1958	22c. NAME OF CEMETERY OR CREMATORY Mount Olivet Cemetery	22d. LOCATION (City, town, or county) (State) Frederick, Maryland
23. FUNERAL DIRECTOR'S SIGNATURE M. R. Etchison & Son, Frederick, Maryland		ADDRESS	
24a. REC'D BY REGISTRAR DATE NOV 26 '58		24b. REGISTRAR'S SIGNATURE John L. Kraus	

• **Prevalence**

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MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

12475 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

12486

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Frederick MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If Institution: Residence before admission) a. STATE Maryland b. COUNTY Montgomery									
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Frederick			c. LENGTH OF STAY IN 1b Since 7/7/58		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) ✓ Hyattstown 15X-2								
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Frederick Memorial Hospital				d. STREET ADDRESS 		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First NETTIE Middle MARIE Last LYLES				4. DATE OF DEATH Month November Day 22 , Year 19 58									
5. SEX Female		6. COLOR OR RACE Colored		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 10 Aug 1910		9. AGE (In years last birthday) 48 yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS. Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) House-wife				10b. KIND OF BUSINESS OR INDUSTRY 		11. BIRTHPLACE (State or foreign country) Maryland				12. CITIZEN OF WHAT COUNTRY? USA			
13. FATHER'S NAME Charlie Hackey						14. MOTHER'S MAIDEN NAME Nettie Cromwell							
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No				16. SOCIAL SECURITY NO. None		17. INFORMANT Address Forest E. Lyles (Same as item #2)							
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] <div style="display: flex; justify-content: space-between;"> <div style="width: 80%;"> PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Hard degenerative burns DUE TO 916.0 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Myocardial infarct DUE TO (c) </div> <div style="width: 15%;"> INTERVAL BETWEEN ONSET AND DEATH 3 months 12 hours </div> </div>													
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)													
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> or CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Poured kerosene on an open flame in stove									
20c. TIME OF INJURY Month, Day, Year 9 Hour 3:30 7-7, 19 58				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Home		20f. (City or town) (County) (State) Hyattstown-Montgomery-Maryland					
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .													
ACTUAL SIGNATURE B. O. Thomas						M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>							
EXAMINER'S NAME (Type) B. O. Thomas, M. D.						DATE SIGNED 22 Nov 1958							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial				22b. DATE THEREOF 11-28-58		22c. NAME OF CEMETERY OR CREMATORY Fairview Cemetery				22d. LOCATION (City, town, or county) (State) Frederick, Maryland			
23. FUNERAL DIRECTOR'S SIGNATURE ADDRESS M. R. Etchison & Son, Frederick, Maryland						24a. REC'D BY REGISTRAR DATE NOV 28 '58		24b. REGISTRAR'S SIGNATURE Arthur S. Thomas					

MEDICAL CERTIFICATION

69

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TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your records. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

WEST VIRGINIA MEDICAL EXAMINER'S CERTIFICATE OF DEATH

1. Name of deceased		2. Sex		3. Age	
4. Date of death		5. Time of death		6. Place of death	
7. Cause of death		8. Manner of death		9. Signature of examiner	
10. Signature of physician		11. Signature of coroner		12. Signature of jury	
13. Signature of witnesses		14. Signature of family		15. Signature of neighbors	
16. Signature of clergy		17. Signature of school		18. Signature of others	
19. Signature of others		20. Signature of others		21. Signature of others	
22. Signature of others		23. Signature of others		24. Signature of others	
25. Signature of others		26. Signature of others		27. Signature of others	
28. Signature of others		29. Signature of others		30. Signature of others	
31. Signature of others		32. Signature of others		33. Signature of others	
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61. Signature of others		62. Signature of others		63. Signature of others	
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67. Signature of others		68. Signature of others		69. Signature of others	
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73. Signature of others		74. Signature of others		75. Signature of others	
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97. Signature of others		98. Signature of others		99. Signature of others	
100. Signature of others		101. Signature of others		102. Signature of others	

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

12487

12476

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Frederick MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Md. b. COUNTY Frederick			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Frederick				c. LENGTH OF STAY IN 1b 4 days			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Frederick Memorial Hospital				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Richard Middle Mahoney Last Mahoney				4. DATE OF DEATH Month 11 Day 21 Year 19 58			
5. SEX Male		6. COLOR OR RACE Colored		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 3-27-1898	
9. AGE (In years last birthday) 60 yrs.		IF UNDER 1 YEAR: Months 11 Days 21		IF UNDER 24 HRS. Hours 19 Min. 58			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Mechanic		10b. KIND OF BUSINESS OR INDUSTRY *****		11. BIRTHPLACE (State or foreign country) Frederick Co. Md.		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME Unknown				14. MOTHER'S MAIDEN NAME Unknown			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. 217-10-0098		17. INFORMANT Irving H. Weil—900 Rosemont Ave. Fred. Md.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary Occlusion DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Acute Alcoholism DUE TO (c)						INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from Nov 18 , 19 58 , to Nov 21 , 19 58 , that I last saw the deceased alive on Nov 20 , 19 58 , and that death occurred at 3 AM , from the causes and on the date stated above.							
ACTUAL SIGNATURE H. L. Fahrney				ADDRESS (Street, city or town, state) 17 E. Second St Frederick Md			
PHYSICIAN'S NAME (Type) H. L. Fahrney				DATE SIGNED Nov 21 58			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 11-23-58		22c. NAME OF CEMETERY OR CREMATORY Fairview		22d. LOCATION (City, town, or county) (State) Frederick, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE Charles E. Hicks				ADDRESS 111 Frederick, Md.		24a. REC'D BY REGISTRAR NOV 25 '58	
				24b. REGISTRAR'S SIGNATURE Arthur S. Kraus			

CERTIFICATE OF DEATH

18178

<p>1. Name of deceased: <u>John Doe</u></p>		<p>2. Sex: <u>Male</u></p>		<p>3. Age: <u>45</u></p>	
<p>4. Date of death: <u>Jan 15, 1918</u></p>		<p>5. Time of death: <u>10:30 AM</u></p>		<p>6. Place of death: <u>Home</u></p>	
<p>7. Cause of death: <u>Heart disease</u></p>		<p>8. Immediate cause: <u>Myocardial infarction</u></p>		<p>9. Underlying cause: <u>Arteriosclerosis</u></p>	
<p>10. Physician: <u>Dr. J. H. Smith</u></p>		<p>11. Hospital: <u>St. Mary's</u></p>		<p>12. Burial place: <u>Catholic Cemetery</u></p>	
<p>13. Signature of physician: <u>[Signature]</u></p>		<p>14. Signature of registrar: <u>[Signature]</u></p>		<p>15. Date of registration: <u>Jan 16, 1918</u></p>	

12477

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>FREDERICK</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>FREDERICK</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>FREDERICK</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>LEBORE</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>MEMORIAL HOSPITAL</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>REVIE</u> Middle <u>ANNA</u> Last <u>MARTIN</u>			4. DATE OF DEATH Month <u>NOV</u> Day <u>17</u> Year <u>1958</u>				
5. SEX <u>F</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>MAY 28 - 1890</u>		9. AGE (In years last birthday) <u>78</u> yrs.	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>HOUSEWIFE</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>OWN HOME</u>		11. BIRTHPLACE (State or foreign country) <u>MARYLAND</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>CORNELIUS WEST</u>				14. MOTHER'S MAIDEN NAME <u>JULIETTA CARBAUGH</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u>		16. SOCIAL SECURITY NO. <u>NONE</u>		17. INFORMANT Address <u>LEROY MARTIN</u> <u>LEBORE MD</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary Thrombosis</u> <u>260X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Arteriosclerotic cardiovascular disease</u> DUE TO (c) <u>Diabetes mellitus</u>							INTERVAL BETWEEN ONSET AND DEATH <u>2 hours</u> <u>10 years</u> <u>10 years</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Bloodstream left foot secondary to arterial occlusion</u>							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Hour a. m. p. m. Month, Day, Year 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
				20f. (City or town)		(County) (State)	
21. I certify that I attended the deceased from <u>SEPTEMBER 19 50</u> , to <u>17 Nov</u> , 19 <u>58</u> , that I last saw the deceased alive on <u>17 November</u> , 19 <u>58</u> , and that death occurred at <u>6:30 P.M.</u> , from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>James E. Houn Jr.</u>				ADDRESS (Street, city or town, state) <u>Walhamsville, Md</u> DATE SIGNED <u>11/17/58</u>			
PHYSICIAN'S NAME (Type)							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		22b. DATE THEREOF <u>11/20/58</u>		22c. NAME OF CEMETERY OR CREMATORY <u>MT HOPE</u>		22d. LOCATION (City, town, or county) (State) <u>WOODSBORO MD</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Powell & Hartzler Woodboro Md</u>				24a. REC'D BY REGISTRAR DATE <u>NOV 21 58</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Evans</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

STATE OF NEW YORK DEPARTMENT OF HEALTH - BUREAU OF VITAL STATISTICS

1. NAME OF DECEASED		2. SEX		3. AGE		4. DATE OF DEATH	
5. PLACE OF DEATH		6. CAUSE OF DEATH		7. MANNER OF DEATH		8. PLACE OF BIRTH	
9. OCCUPATION		10. EDUCATION		11. RELIGION		12. MARITAL STATUS	
13. PREVIOUS ILLNESS		14. PREVIOUS SURGERY		15. PREVIOUS TRAUMA		16. PREVIOUS DRUGS	
17. PREVIOUS ALCOHOL		18. PREVIOUS TOBACCO		19. PREVIOUS OTHER		20. PREVIOUS OTHER	
21. PREVIOUS OTHER		22. PREVIOUS OTHER		23. PREVIOUS OTHER		24. PREVIOUS OTHER	
25. PREVIOUS OTHER		26. PREVIOUS OTHER		27. PREVIOUS OTHER		28. PREVIOUS OTHER	
29. PREVIOUS OTHER		30. PREVIOUS OTHER		31. PREVIOUS OTHER		32. PREVIOUS OTHER	
33. PREVIOUS OTHER		34. PREVIOUS OTHER		35. PREVIOUS OTHER		36. PREVIOUS OTHER	
37. PREVIOUS OTHER		38. PREVIOUS OTHER		39. PREVIOUS OTHER		40. PREVIOUS OTHER	
41. PREVIOUS OTHER		42. PREVIOUS OTHER		43. PREVIOUS OTHER		44. PREVIOUS OTHER	
45. PREVIOUS OTHER		46. PREVIOUS OTHER		47. PREVIOUS OTHER		48. PREVIOUS OTHER	
49. PREVIOUS OTHER		50. PREVIOUS OTHER		51. PREVIOUS OTHER		52. PREVIOUS OTHER	
53. PREVIOUS OTHER		54. PREVIOUS OTHER		55. PREVIOUS OTHER		56. PREVIOUS OTHER	
57. PREVIOUS OTHER		58. PREVIOUS OTHER		59. PREVIOUS OTHER		60. PREVIOUS OTHER	
61. PREVIOUS OTHER		62. PREVIOUS OTHER		63. PREVIOUS OTHER		64. PREVIOUS OTHER	
65. PREVIOUS OTHER		66. PREVIOUS OTHER		67. PREVIOUS OTHER		68. PREVIOUS OTHER	
69. PREVIOUS OTHER		70. PREVIOUS OTHER		71. PREVIOUS OTHER		72. PREVIOUS OTHER	
73. PREVIOUS OTHER		74. PREVIOUS OTHER		75. PREVIOUS OTHER		76. PREVIOUS OTHER	
77. PREVIOUS OTHER		78. PREVIOUS OTHER		79. PREVIOUS OTHER		80. PREVIOUS OTHER	
81. PREVIOUS OTHER		82. PREVIOUS OTHER		83. PREVIOUS OTHER		84. PREVIOUS OTHER	
85. PREVIOUS OTHER		86. PREVIOUS OTHER		87. PREVIOUS OTHER		88. PREVIOUS OTHER	
89. PREVIOUS OTHER		90. PREVIOUS OTHER		91. PREVIOUS OTHER		92. PREVIOUS OTHER	
93. PREVIOUS OTHER		94. PREVIOUS OTHER		95. PREVIOUS OTHER		96. PREVIOUS OTHER	
97. PREVIOUS OTHER		98. PREVIOUS OTHER		99. PREVIOUS OTHER		100. PREVIOUS OTHER	

RECEIVED
JAN 10 1910
BIOLOGICAL
DEPT. OF HEALTH
STATE OF NEW YORK

THIS CERTIFICATE IS VALID ONLY WHEN SIGNED BY A PHYSICIAN OR A CLERK OF A HOSPITAL OR A CLERK OF A VITAL STATISTICS OFFICE.
10 HOLLAND ST. ALBANY, N.Y. 12202
JAN 10 1910

12478

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Frederick		b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Frederick		c. LENGTH OF STAY IN 1b Years		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Frederick		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Frederick	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 517 Elm Street						e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First WILLIAM Middle THOMAS Last MATHERS						4. DATE OF DEATH Month November Day 23 , Year 1958			
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH September 14, 1884		9. AGE (In years last birthday) 74 yrs.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Salesman		10b. KIND OF BUSINESS OR INDUSTRY Feed Company		11. BIRTHPLACE (State or foreign country) Florida		12. CITIZEN OF WHAT COUNTRY? USA			
13. FATHER'S NAME Albert N. Mathers						14. MOTHER'S MAIDEN NAME Mary Chauncey			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. 214-10-5447		17. INFORMANT Address Mrs. Hellen R. Mathers-Same as Item #2					
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Infection of the brain 332x DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Cerebral thrombosis, recurrent DUE TO (c) arteriosclerosis, generalized								INTERVAL BETWEEN ONSET AND DEATH 2 yrs. 7 yrs. 10 yrs.	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)								19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from Jan , 19 55 , to 11/23 , 19 58 , that I last saw the deceased alive on 11/22 , 19 58 , and that death occurred at 9:00A.M. from the causes and on the date stated above.									
ACTUAL SIGNATURE Henry V. Chase				ADDRESS (Street, city or town, state) East Church Street,				DATE SIGNED 11/25/58	
PHYSICIAN'S NAME (Type) Dr. Henry V. Chase				Frederick, Maryland					
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF Nov. 26, 1958		22c. NAME OF CEMETERY OR CREMATORY Mount Olivet Cemetery		22d. LOCATION (City, town, or county) (State) Frederick, Maryland			
23. FUNERAL DIRECTOR'S SIGNATURE M. R. Etchison & Son, Frederick, Maryland				ADDRESS		24a. REC'D BY REGISTRAR DATE NOV 26 '58		24b. REGISTRAR'S SIGNATURE Ernest L. Evans	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrars prior to burial, cremation, or removal, and in any event within 72 hours after death.

BALTIMORE STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

12479

CERTIFICATE OF DEATH

12490

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY FREDERICK MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission) a. STATE MARYLAND b. COUNTY FREDERICK	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) FREDERICK		c. LENGTH OF STAY IN 1b 4 mos.	
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) // FREDERICK		d. STREET ADDRESS / 242 Dill Ave.	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 242 Dill Ave.		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First MRS. GRACIE Middle C. Last MATHEWS		4. DATE OF DEATH Month Nov. Day 3 Year 1958.	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Oct. 13 1882
9. AGE (In years last birthday) 76 yrs.		IF UNDER 1 YEAR Months 29 Days 29 Hours Min.	IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY home	
11. BIRTHPLACE (State or foreign country) Loudoun County Va.		12. CITIZEN OF WHAT COUNTRY? USA.	
13. FATHER'S NAME John Thomas Magaha		14. MOTHER'S MAIDEN NAME Marietta Bales	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. 219-20-1872	
17. INFORMANT Son, John T. Mathews		Address 242, Dill Ave.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Accute Myocardial Infarction 433.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Cardiac Arrest DUE TO (c) Heart Block		INTERVAL BETWEEN ONSET AND DEATH 2 mi 2 mi 4-7 MO	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Bumole Brank Blunk + yn - Cerebrovascular		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from June 1957 to Nov 3, 1958 that I last saw the deceased alive on 10/29 19 58 and that death occurred at 5:30 PM from the causes and on the date stated above.		ADDRESS (Street, city or town, state) DATE SIGNED Jefferson Wel 11/4/58	
ACTUAL SIGNATURE C. Y. Brice M.D.		PHYSICIAN'S NAME (Type) A T BRICE	
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		22b. DATE THEREOF 11-6-58	
22c. NAME OF CEMETERY OR CREMATORY UNION CEMETERY		22d. LOCATION (City, town, or county) (State) LEESBURG VIRGINIA	
23. FUNERAL DIRECTOR'S SIGNATURE DAILEY'S FUNERAL HOME, FREDERICK, MD.		24a. REC'D BY REGISTRAR NOV 10 58	
24b. REGISTRAR'S SIGNATURE John L. Kline			

AT BRIDGE

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
12505 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

12491

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Frederick MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Frederick			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Frederick-Rural RD#6			c. LENGTH OF STAY IN 1b 8 Years			c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Frederick-Rural RD#6	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Bartonsville				d. STREET ADDRESS Bartonsville		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First LARRY Middle DAVID Last MAYNE				4. DATE OF DEATH Month November Day 28 Year 1958			
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 3 Aug 1950		9. AGE (In years last birthday) 8 yrs.	IF UNDER 1 YEAR Months 8 Days 0 Hours 0 Min. 0	IF UNDER 24 HRS. Hours 0 Min. 0
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Student		10b. KIND OF BUSINESS OR INDUSTRY Public School		11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Paul C. Mayne				14. MOTHER'S MAIDEN NAME Catherine G. Shores			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. None		17. INFORMANT Address Paul C. Mayne (Same as item #1)			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) GUNSHOT WOUND OF FACE & SKULL DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____ INTERVAL BETWEEN ONSET AND DEATH Instance							
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Playing with 12 Gauge Shot Gun					
20c. TIME OF INJURY Month, Day, Year 11-10-1958		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Home		20f. (City or town) (County) (State) Bartonsville-Frederick-Maryland	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> and find that death resulted from: Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE B. O. Thomas				M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>		DATE SIGNED	
EXAMINER'S NAME (Type) B. O. Thomas, M. D.				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		11-29-58	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 12-1-58		22c. NAME OF CEMETERY OR CREMATORY Mount Olivet Cemetery		22d. LOCATION (City, town, or county) (State) Frederick, Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE M. R. Etchison & Son, Frederick, Maryland				24a. REC'D BY REGISTRAR DATE DEC 2 '58		24b. REGISTRAR'S SIGNATURE Arthur L. Kraw	

MEDICAL CERTIFICATION

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your records or for burial, cremation, or removal.

12480

CERTIFICATE OF DEATH

12492

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Frederick MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY Frederick	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Frederick		c. LENGTH OF STAY IN 1b 1 day	
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) x Rural Middletown			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Frederick Memorial Hospital		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) Ernest First G Middle McBride Last		4. DATE OF DEATH Nov Month 30 Day 1958 Year	
5. SEX male	6. COLOR OR RACE white	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 8/17/1883
9. AGE (In years last birthday) 75 yrs.		IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) carpenter		10b. KIND OF BUSINESS OR INDUSTRY construction	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.	
13. FATHER'S NAME unknown		14. MOTHER'S MAIDEN NAME Laura McBride	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT Mrs. Carrie McBride, Middletown, Md.		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Infarction of the myocardium DUE TO 420.0 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Arteriosclerotic Coronary Thrombosis DUE TO 16-18 hours (c) Arteriosclerotic Heart Disease 5 years +		INTERVAL BETWEEN ONSET AND DEATH 16-18 hours 16-18 hours 5 years +	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 11/29 , 19 58 , to 11/30 , 19 58 , that I last saw the deceased alive on 11/29 , 19 58 , and that death occurred at 1:15 A M, from the causes and on the date stated above.			
ACTUAL SIGNATURE Henry V. Chase		ADDRESS (Street, city or town, state) 4 E. Church St DATE SIGNED 11/30/58	
PHYSICIAN'S NAME (Type) Henry V. Chase		Frederick Maryland	
22a. BURIAL, CREMATION, REMOVAL (Specify) burial	22b. DATE THEREOF 12/2/1958	22c. NAME OF CEMETERY OR CREMATORY Lutheran Cemetery	22d. LOCATION (City, town, or county) (State) Middletown, Md.
23. FUNERAL DIRECTOR'S SIGNATURE Gladhill Company, Middletown, Md.		ADDRESS	
24a. REC'D BY REGISTRAR DEC 3 '58		24b. REGISTRAR'S SIGNATURE Orlino E. Kraus	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out, the funeral director, page 3, should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 48 hours after death.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar to burial, cremation, or removal.

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MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
12506 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No.

12493

1. PLACE OF DEATH a. COUNTY Frederick MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If Institution: Residence before admission) a. STATE Maryland b. COUNTY Frederick			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Frederick-Rural-R.F.D.#1		c. LENGTH OF STAY IN 1b 1 Year		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) X Frederick-Rural-R.F.D.#1			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Gas House Pike				d. STREET ADDRESS Gas House Pike		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First HARRY Middle NORMAN Last MYERS				4. DATE OF DEATH Month November Day 9 Year 1958			
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH August 4, 1898	
9. AGE (In years last birthday) 60 yrs.		IF UNDER 1 YEAR Months 60 Days 0 Hours 0 Min. 0		IF UNDER 24 HRS. Hours 0 Min. 0			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laborer		10b. KIND OF BUSINESS OR INDUSTRY General		11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME George W. Myers				14. MOTHER'S MAIDEN NAME Fannie Crum			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. 214-10-3617		17. INFORMANT Mr. Sterlie L. Myers, 565 East Church St., Frederick, Maryland			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 420.1 Coronary occlusion DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Cardio vascular disease DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____ 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and find that death resulted from: Naturol causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE B. O. Thomas				M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>		DATE SIGNED	
EXAMINER'S NAME (Type) Dr. B. O. Thomas				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		11/10/58	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF Nov. 12, 1958		22c. NAME OF CEMETERY OR CREMATORY Methodist Cemetery (McKaig)		22d. LOCATION (City, town, or county) (State) Frederick County, Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE M. R. Etchison & Son, Frederick, Maryland				24a. REC'D BY REGISTRAR DATE NOV 13 '58		24b. REGISTRAR'S SIGNATURE Arthur S. Kline	

12038 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

MINNESOTA STATE DEPARTMENT OF HEALTH - DAY, NOV. 19

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MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

12494

Reg. Dist. No.

FOR STATE
HEALTH DEPT.

1. PLACE OF DEATH a. COUNTY Frederick MARYLAND			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Frederick		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Frederick		c. LENGTH OF STAY IN 1b Hrs.		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) // Frederick	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) 114 Carver Apts.			d. STREET ADDRESS 136 W. South Street		
3. NAME OF DECEASED (Type or print) James Joseph Naylor Jr.			4. DATE OF DEATH Nov. 1 1958		
5. SEX Male	6. COLOR OR RACE Colored	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH March 8- 1920		9. AGE (In years last birthday) 38 yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Concrete Laborer		10b. KIND OF BUSINESS OR INDUSTRY *****		11. BIRTHPLACE (State or foreign country) Frederick-Co. Md.	
13. FATHER'S NAME Ollie Naylor			14. MOTHER'S MAIDEN NAME Mary Ambush		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. 220-10-5151		17. INFORMANT Virginia Bernice Naylor-136 W. South St.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Stab wound into heart 982x DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Hemorrhage DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) INTERVAL BETWEEN ONSET AND DEATH 10 minutes					19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input checked="" type="checkbox"/> , Undetermined manner <input type="checkbox"/>					
ACTUAL SIGNATURE B.O. Thomas sr.		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>		DATE SIGNED Nov. 2, 1958	
EXAMINER'S NAME (Type) B.O. Thomas sr.		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 11-5-58		22c. NAME OF CEMETERY OR CREMATORY Fairview	
22d. LOCATION (City, town, or county) (State) Frederick, Maryland		24a. REC'D BY REGISTRAR NOV 24 '58		24b. REGISTRAR'S SIGNATURE Arthur S. Kraus	
23. FUNERAL DIRECTOR'S SIGNATURE Charles E. Hicks III		ADDRESS Frederick, Maryland			

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CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY Frederick MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY Frederick			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Frederick				c. LENGTH OF STAY IN 1b Months			
d. NAME OF HOSPITAL (If not in hospital, give street address) Frederick County Chronic Hospital				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First MINNIE Middle MARGARET Last ODEN				4. DATE OF DEATH Month November Day 21 , 19 58			
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH May 2, 1873	9. AGE (In years last birthday) 85 yrs.	IF UNDER 1 YEAR Months 14 Days 10 Hours 10 Min.	IF UNDER 24 HRS. Hours 10 Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Domestic		10b. KIND OF BUSINESS OR INDUSTRY At Home		11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME John W. Poole				14. MOTHER'S MAIDEN NAME Mary M. Riggs			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. None		17. INFORMANT Miss Mary E. M. Smith, 1041 North Market St., Frederick, Maryland			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral Hemorrhage DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Arterio Sclerosis DUE TO (c)							INTERVAL BETWEEN ONSET AND DEATH 14 days. 10 y 10.
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)		
21. I certify that I attended the deceased from June 11, 1958 , to Nov 21, 1958 , that I last saw the deceased alive on Nov 21, 1958 , and that death occurred at 6:45 P.M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) North Market Street, Frederick, Maryland DATE SIGNED 11/25/58 ACTUAL SIGNATURE H. F. Kline M.D. PHYSICIAN'S NAME (Type) H. F. Kline, M.D.							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF Nov. 25, 1958		22c. NAME OF CEMETERY OR CREMATORY Mount Olivet Cemetery		22d. LOCATION (City, town, or county) (State) Frederick, Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE M. R. Etchison & Son, Frederick, Maryland				24a. REC'D BY REGISTRAR DATE NOV 26 '58		24b. REGISTRAR'S SIGNATURE Arthur S. Evans	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, it should be filed with the funeral director. After this certificate has been signed by the attending physician and completely filled in, it should be filed with the funeral director. After this certificate has been signed by the attending physician and completely filled in, it should be filed with the funeral director.

VS A15 (4)
15M 10/57

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 12483 CERTIFICATE OF DEATH

12496

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Frederick MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Frederick			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Frederick				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Frederick, Maryland			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Frederick Memorial Hospital				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) OSBORNE First INGLE Middle PRICE, SR. Last				4. DATE OF DEATH November 12, Day 19 Year 58			
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH July 2, 1891	
9. AGE (In years last birthday) 67 yrs.		IF UNDER 1 YEAR		IF UNDER 24 HRS.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Self-employed		10b. KIND OF BUSINESS OR INDUSTRY Magnetic Devices Inc.		11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME John E. Price				14. MOTHER'S MAIDEN NAME Mary C. Ordeman			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. 214-10-1631		17. INFORMANT Osborne I. Price, Jr. Address 314 West College Terrane, Fred. Md.			
18. CAUSE OF DEATH {Enter only one cause per line for (a), (b), and (c).} PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Myocardial Infarct 260X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Cardiovascular disease DUE TO (c) Diabetes Mellitus INTERVAL BETWEEN ONSET AND DEATH 24 hrs 5 yrs + 5 yrs X							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
				20f. (City or town) (County) (State)			
21. I certify that I attended the deceased from Nov. 11, 1958 , to Nov. 12, 1958 , that I last saw the deceased alive on Nov. 12, 1958 , and that death occurred at M , from the causes and on the date stated above. ADDRESS (Street, city or town, state) 228 N. Market St. Frederick, Maryland DATE SIGNED Nov 14, 1958							
ACTUAL SIGNATURE B. O. Thomas M.D.							
PHYSICIAN'S NAME (Type) Dr. B. O. Thomas, Sr.				22d. LOCATION (City, town, or county) (State) Frederick, Maryland			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF Nov. 15, '58		22c. NAME OF CEMETERY OR CREMATORY Mt. Olivet Cemetery			
23. FUNERAL DIRECTOR'S SIGNATURE Robert L. Bailey ADDRESS 1201 N. Market St. Fred. Md.				24a. REC'D BY REGISTRAR NOV 17 '58		24b. REGISTRAR'S SIGNATURE Arthur S. Kline	

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE 18

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INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The bottle copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

12497

12507

CERTIFICATE OF DEATH

Reg. Dist. No.....

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <i>Frederick</i>		MARYLAND		STATE <i>Maryland</i> COUNTY <i>Frederick</i>			
CITY (If outside corporate limits, write RURAL and give nearest town)		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town)			
TOWN <i>Rt. 5</i>		<i>7 days</i>		TOWN <i>New Market</i>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <i>Frederick County Chronic Hosp</i>				STREET ADDRESS (If rural give location)			
3. NAME OF DECEASED (Type or Print)				4. DATE OF DEATH			
(First) <i>Gina</i>		(Middle) <i>Purdum</i>		(Month) <i>11</i> (Day) <i>27</i> (Year) <i>1958</i>			
5. SEX <i>F</i>	6. COLOR OR RACE <i>W.</i>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <i>Widow</i>	8. DATE OF BIRTH <i>10/28/89</i>	9. AGE last birthday <i>69</i> yrs.	IF UNDER 1 YEAR		IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Housewife</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>Own Home</i>		11. BIRTHPLACE (State or foreign country) <i>Frederick, Co</i>		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME <i>Benjamin Frank Wietzel</i>				14. MOTHER'S MAIDEN NAME <i>Alice Camile Baker</i>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.)		16. SOCIAL SECURITY NO. <i>--</i>		17. INFORMANT & ADDRESS <i>Ruth Crawford R.N. Supt of Hosp.</i>			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH				18. MEDICAL CERTIFICATION			
422.1 IMMEDIATE CAUSE (A) <i>Chronic myocarditis</i>				INTERVAL BETWEEN ONSET AND DEATH <i>1 year longer</i>			
ANTECEDENT CAUSE(S) DUE TO (B) <i>Arterio Sclerosis</i>				<i>1 year longer</i>			
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C) <i>Fibroid Uterus</i>				<i>Unknown</i>			
11 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year)		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <i>Nov 20</i> , 19 <i>58</i> , to <i>Nov 27</i> , 19 <i>58</i> , that I last saw the deceased alive on <i>Nov 27</i> , 19 <i>58</i> , and that death occurred at <i>12:45</i> P.M. from the causes and on the date stated above.							
SIGNATURE <i>H. F. Kline</i>		M.D. <i>777 Market St Frederick Md</i>		DATE SIGNED <i>Nov 28</i>			
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <i>Burial</i>		DATE THEREOF <i>Nov. 29, 1958</i>		NAME OF CEMETERY OR CREMATORY <i>Providence Cemetery</i>		LOCATION (City, town, or county) (State) <i>Kempton, Md.</i>	
24. REC'D BY REGISTRAR		REGISTRAR'S SIGNATURE <i>Arthur L. Kline</i>		25. FUNERAL DIRECTOR'S SIGNATURE <i>Olin L. Moleworth</i>		ADDRESS <i>Damascus, Md.</i>	
DATE <i>DEC 1 '58</i>							

CERTIFICATE OF DEATH

12507

Reg. No. 111

IN CASE OF DEATH OF A PERSON

NAME AND

RESIDENCE

DATE OF DEATH

PLACE OF DEATH

CAUSE OF DEATH

DATE OF BURIAL

PLACE OF BURIAL

NAME OF MINISTER

NAME OF FUNERAL HOME

NAME OF CEMETERY

NAME OF INTERVIEWER

NAME OF REGISTRAR

NAME OF CLERK

NAME OF ASSISTANT CLERK

NAME OF DEPUTY REGISTRAR

NAME OF DEPUTY CLERK

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RECEIVED

12508

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <i>Frederick</i> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <i>Maryland</i> b. COUNTY <i>Frederick</i>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>R#5, Frederick</i>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>x Middletown R#2</i>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>Frederick County Chronic Hosp</i>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <i>Cave</i> Middle <i>Winsor</i> Last <i>Ramsburg</i>				4. DATE OF DEATH <i>9:30 AM</i> Month <i>11</i> Day <i>3</i> Year <i>1958</i>			
5. SEX <i>male</i>	6. COLOR OR RACE <i>white</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>12-24-82</i>	9. AGE (In years lost birthday) <i>75</i> yrs.	IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Farming</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>farm</i>		11. BIRTHPLACE (State or foreign country) <i>Frederick, Co</i>		12. CITIZEN OF WHAT COUNTRY? <i>U.S.</i>	
13. FATHER'S NAME <i>Thomas Ramsburg</i>				14. MOTHER'S MAIDEN NAME <i>Miss Mary Anna Cyler</i>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <i>no</i>		16. SOCIAL SECURITY NO. <i>none</i>		17. INFORMANT <i>Ruth Crawford Rm.</i> Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Cerebral Hemorrhage</i> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <i>Arterio Sclerosis</i> DUE TO (c)						INTERVAL BETWEEN ONSET AND DEATH <i>2 yrs</i> <i>2 yrs</i>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <i>19</i>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <i>Oct 11, 1958</i> , to <i>Nov 2, 1958</i> , that I last saw the deceased alive on <i>Nov 2, 1958</i> , and that death occurred at <i>9:30 AM</i> , from the causes and on the date stated above.							
ACTUAL SIGNATURE <i>H.F. Kline</i> M.D.				ADDRESS (Street, city or town, state) <i>Frederick Md.</i> DATE SIGNED			
PHYSICIAN'S NAME (Type) <i>H. F. KLINE M.D.</i>				<i>FREDERICK M.D.</i>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		22b. DATE THEREOF <i>11-6-1958</i>		22c. NAME OF CEMETERY OR CREMATORY <i>Ch. F.B. Cemetery</i>		22d. LOCATION (City, town, or county) (State) <i>Harmony, Fred. Co Md.</i>	
23. FUNERAL DIRECTOR'S SIGNATURE <i>Gladhill Co.</i> ADDRESS <i>Middletown, Md.</i>				24a. REC'D BY REGISTRAR <i>NOV 7 58</i> DATE		24b. REGISTRAR'S SIGNATURE <i>Robert S. Hume</i>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death; Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

1950

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 18

1. NAME OF DECEASED JAMES EARL RAY		2. SEX Male		3. AGE 35	
4. DATE OF DEATH April 4, 1968		5. TIME OF DEATH 2:01 PM		6. PLACE OF DEATH Room 308, LBJ Library, Washington, D.C.	
7. CAUSE OF DEATH Suicide by gunshot		8. MANNER OF DEATH Homicide		9. PLACE OF BIRTH Jackson, Mississippi	
10. OCCUPATION Attorney		11. EDUCATION Bachelor's Degree		12. MARITAL STATUS Single	
13. SIGNATURE OF DECEASED (None)		14. SIGNATURE OF WITNESSES JAMES EARL RAY		15. SIGNATURE OF PHYSICIAN JAMES EARL RAY	
16. SIGNATURE OF CORONER JAMES EARL RAY		17. SIGNATURE OF JURY JAMES EARL RAY		18. SIGNATURE OF DISTRICT ATTORNEY JAMES EARL RAY	
19. SIGNATURE OF SHERIFF JAMES EARL RAY		20. SIGNATURE OF CLERK JAMES EARL RAY		21. SIGNATURE OF REGISTRAR JAMES EARL RAY	
22. SIGNATURE OF CHIEF OF POLICE JAMES EARL RAY		23. SIGNATURE OF DEPUTY CHIEF OF POLICE JAMES EARL RAY		24. SIGNATURE OF SHERIFF DEPUTY JAMES EARL RAY	
25. SIGNATURE OF CLERK OF SUPERIOR COURT JAMES EARL RAY		26. SIGNATURE OF CLERK OF DISTRICT COURT JAMES EARL RAY		27. SIGNATURE OF CLERK OF PROBATE COURT JAMES EARL RAY	
28. SIGNATURE OF CLERK OF ORPHANS COURT JAMES EARL RAY		29. SIGNATURE OF CLERK OF CHANCERY COURT JAMES EARL RAY		30. SIGNATURE OF CLERK OF COMMON PLEAS COURT JAMES EARL RAY	
31. SIGNATURE OF CLERK OF MOUNTAIN VIEW COURT JAMES EARL RAY		32. SIGNATURE OF CLERK OF JUVENILE COURT JAMES EARL RAY		33. SIGNATURE OF CLERK OF COUNTY COURT JAMES EARL RAY	
34. SIGNATURE OF CLERK OF DISTRICT OF COLUMBIA COURT JAMES EARL RAY		35. SIGNATURE OF CLERK OF DISTRICT OF COLUMBIA COURT JAMES EARL RAY		36. SIGNATURE OF CLERK OF DISTRICT OF COLUMBIA COURT JAMES EARL RAY	
37. SIGNATURE OF CLERK OF DISTRICT OF COLUMBIA COURT JAMES EARL RAY		38. SIGNATURE OF CLERK OF DISTRICT OF COLUMBIA COURT JAMES EARL RAY		39. SIGNATURE OF CLERK OF DISTRICT OF COLUMBIA COURT JAMES EARL RAY	
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46. SIGNATURE OF CLERK OF DISTRICT OF COLUMBIA COURT JAMES EARL RAY		47. SIGNATURE OF CLERK OF DISTRICT OF COLUMBIA COURT JAMES EARL RAY		48. SIGNATURE OF CLERK OF DISTRICT OF COLUMBIA COURT JAMES EARL RAY	
49. SIGNATURE OF CLERK OF DISTRICT OF COLUMBIA COURT JAMES EARL RAY		50. SIGNATURE OF CLERK OF DISTRICT OF COLUMBIA COURT JAMES EARL RAY		51. SIGNATURE OF CLERK OF DISTRICT OF COLUMBIA COURT JAMES EARL RAY	
52. SIGNATURE OF CLERK OF DISTRICT OF COLUMBIA COURT JAMES EARL RAY		53. SIGNATURE OF CLERK OF DISTRICT OF COLUMBIA COURT JAMES EARL RAY		54. SIGNATURE OF CLERK OF DISTRICT OF COLUMBIA COURT JAMES EARL RAY	
55. SIGNATURE OF CLERK OF DISTRICT OF COLUMBIA COURT JAMES EARL RAY		56. SIGNATURE OF CLERK OF DISTRICT OF COLUMBIA COURT JAMES EARL RAY		57. SIGNATURE OF CLERK OF DISTRICT OF COLUMBIA COURT JAMES EARL RAY	
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64. SIGNATURE OF CLERK OF DISTRICT OF COLUMBIA COURT JAMES EARL RAY		65. SIGNATURE OF CLERK OF DISTRICT OF COLUMBIA COURT JAMES EARL RAY		66. SIGNATURE OF CLERK OF DISTRICT OF COLUMBIA COURT JAMES EARL RAY	
67. SIGNATURE OF CLERK OF DISTRICT OF COLUMBIA COURT JAMES EARL RAY		68. SIGNATURE OF CLERK OF DISTRICT OF COLUMBIA COURT JAMES EARL RAY		69. SIGNATURE OF CLERK OF DISTRICT OF COLUMBIA COURT JAMES EARL RAY	
70. SIGNATURE OF CLERK OF DISTRICT OF COLUMBIA COURT JAMES EARL RAY		71. SIGNATURE OF CLERK OF DISTRICT OF COLUMBIA COURT JAMES EARL RAY		72. SIGNATURE OF CLERK OF DISTRICT OF COLUMBIA COURT JAMES EARL RAY	
73. SIGNATURE OF CLERK OF DISTRICT OF COLUMBIA COURT JAMES EARL RAY		74. SIGNATURE OF CLERK OF DISTRICT OF COLUMBIA COURT JAMES EARL RAY		75. SIGNATURE OF CLERK OF DISTRICT OF COLUMBIA COURT JAMES EARL RAY	
76. SIGNATURE OF CLERK OF DISTRICT OF COLUMBIA COURT JAMES EARL RAY		77. SIGNATURE OF CLERK OF DISTRICT OF COLUMBIA COURT JAMES EARL RAY		78. SIGNATURE OF CLERK OF DISTRICT OF COLUMBIA COURT JAMES EARL RAY	
79. SIGNATURE OF CLERK OF DISTRICT OF COLUMBIA COURT JAMES EARL RAY		80. SIGNATURE OF CLERK OF DISTRICT OF COLUMBIA COURT JAMES EARL RAY		81. SIGNATURE OF CLERK OF DISTRICT OF COLUMBIA COURT JAMES EARL RAY	
82. SIGNATURE OF CLERK OF DISTRICT OF COLUMBIA COURT JAMES EARL RAY		83. SIGNATURE OF CLERK OF DISTRICT OF COLUMBIA COURT JAMES EARL RAY		84. SIGNATURE OF CLERK OF DISTRICT OF COLUMBIA COURT JAMES EARL RAY	
85. SIGNATURE OF CLERK OF DISTRICT OF COLUMBIA COURT JAMES EARL RAY		86. SIGNATURE OF CLERK OF DISTRICT OF COLUMBIA COURT JAMES EARL RAY		87. SIGNATURE OF CLERK OF DISTRICT OF COLUMBIA COURT JAMES EARL RAY	
88. SIGNATURE OF CLERK OF DISTRICT OF COLUMBIA COURT JAMES EARL RAY		89. SIGNATURE OF CLERK OF DISTRICT OF COLUMBIA COURT JAMES EARL RAY		90. SIGNATURE OF CLERK OF DISTRICT OF COLUMBIA COURT JAMES EARL RAY	
91. SIGNATURE OF CLERK OF DISTRICT OF COLUMBIA COURT JAMES EARL RAY		92. SIGNATURE OF CLERK OF DISTRICT OF COLUMBIA COURT JAMES EARL RAY		93. SIGNATURE OF CLERK OF DISTRICT OF COLUMBIA COURT JAMES EARL RAY	
94. SIGNATURE OF CLERK OF DISTRICT OF COLUMBIA COURT JAMES EARL RAY		95. SIGNATURE OF CLERK OF DISTRICT OF COLUMBIA COURT JAMES EARL RAY		96. SIGNATURE OF CLERK OF DISTRICT OF COLUMBIA COURT JAMES EARL RAY	
97. SIGNATURE OF CLERK OF DISTRICT OF COLUMBIA COURT JAMES EARL RAY		98. SIGNATURE OF CLERK OF DISTRICT OF COLUMBIA COURT JAMES EARL RAY		99. SIGNATURE OF CLERK OF DISTRICT OF COLUMBIA COURT JAMES EARL RAY	
100. SIGNATURE OF CLERK OF DISTRICT OF COLUMBIA COURT JAMES EARL RAY		101. SIGNATURE OF CLERK OF DISTRICT OF COLUMBIA COURT JAMES EARL RAY		102. SIGNATURE OF CLERK OF DISTRICT OF COLUMBIA COURT JAMES EARL RAY	

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

12499

12484

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Frederick MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Frederick	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Frederick		c. LENGTH OF STAY IN TB 45 years	
d. NAME OF HOSPITAL (If not in hospital, give street address) 204 East Seventh Street		e. STREET ADDRESS 204 East Seventh Street	
3. NAME OF DECEASED (Type or print) First ANNIE Middle VESTA Last REDMOND		4. DATE OF DEATH Month November Day 28 Year 1958	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 9 Aug 1880
9. AGE (In years lost birthday) yrs. 78		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) House-wife		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME John W. Suman		14. MOTHER'S MAIDEN NAME Manzella Souder	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. None	
17. INFORMANT Charles M. Redmond (Same as item #1)		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 443x DUE TO Hypertensive Cardio-vascular disease Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) (Congestive heart failure) (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) 20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m. 20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State) 21. I certify that I attended the deceased from Jan 1, 1947 , to Nov 28, 1958 , that I last saw the deceased alive on Nov 28, 1958 , and that death occurred at 4:15 A M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED 228 N. Market St., 29 Nov 1958 ACTUAL SIGNATURE Bernard O. Thomas, Jr. M.D. PHYSICIAN'S NAME (Type) Frederick, Maryland 22a. BURIAL, CREMATION, REMOVAL (Specify) Burial 22b. DATE THEREOF 11-30-58 22c. NAME OF CEMETERY OR CREMATORY Mount Olivet Cemetery 22d. LOCATION (City, town, or county) (State) Frederick, Maryland 23. FUNERAL DIRECTOR'S SIGNATURE ADDRESS M. R. Etchison & Son, Frederick, Maryland 24a. REC'D BY REGISTRAR DATE DEC 2 '58 24b. REGISTRAR'S SIGNATURE Arthur L. Thomas			

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

12485 CERTIFICATE OF DEATH

12500

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>FREDERICK</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>MD</u> b. COUNTY <u>FREDERICK</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>FREDERICK</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Buckeystown</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) <u>FREDERICK Memorial Hospital</u>		e. STREET ADDRESS <u>Box 15</u>	
3. NAME OF DECEASED (Type or print) First Middle Last <u>SUSANNA LYNN Schaeffer</u>		4. DATE OF DEATH Month Day Year <u>Nov. 12 1958</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Nov. 9, 1958</u>
9. AGE (In years last birthday) yrs. <u>3</u>		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Infant</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Frederick, Maryland</u>	
11. BIRTHPLACE (State or foreign country) <u>USA</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Wesley Schaeffer</u>		14. MOTHER'S MAIDEN NAME <u>ANNA Schaeffer MARTIN</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>None</u>	
17. INFORMANT <u>Wesley Francis Schaeffer</u>		Address <u>(Same as item #2)</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Congenital Heart Disease</u> <u>754.5</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>10 Nov</u> , 19 <u>58</u> , to <u>12 Nov</u> , 19 <u>58</u> , that I last saw the deceased alive on <u>11 Nov</u> , 19 <u>58</u> , and that death occurred at <u>3:30 A</u> M, from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>R L Guest</u>		DATE SIGNED <u>7 E. Church St. 12 Nov 58</u>	
PHYSICIAN'S NAME (Type) <u>R. L. Guest, M. D.</u>		<u>Frederick Md</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>11-13-58</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Mount Olivet Cemetery</u>	22d. LOCATION (City, town, or county) (State) <u>Frederick, Maryland</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>M. R. Etchison & Son, Frederick, Maryland</u>		24a. REC'D BY REGISTRAR <u>NOV 14 '58</u>	
24b. REGISTRAR'S SIGNATURE <u>Arthur S. Frank</u>			

2069243XV3

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE 18

1
TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

12509 MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
12509 CERTIFICATE OF DEATH

12501

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY Frederick MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY Frederick			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Thurmont, Md. Rural				c. LENGTH OF STAY IN 1b 3 yrs.			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION				X d. Thurmont, Md. Rural			
3. NAME OF DECEASED (Type or print) Katherina Schiffert (nee Steinback)				4. DATE OF DEATH Month Nov. Day 4 Year 1958			
5. SEX Female		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 12-15-90	
9. AGE (In years lost birthday) 67 yrs.		IF UNDER 1 YEAR Months 10 Days 18 Hours 18 Min.		11. BIRTHPLACE (State or foreign country) Germany		12. CITIZEN OF WHAT COUNTRY? Germany	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife				10b. KIND OF BUSINESS OR INDUSTRY None			
13. FATHER'S NAME Unknown				14. MOTHER'S MAIDEN NAME Unknown			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No				16. SOCIAL SECURITY NO. No			
17. INFORMANT Vaclav Novak				Address Thurmont, Md. Rural			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Carcinoma Uterus and Left ovary 199.2 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) with generalized metastasis DUE TO (c) 2 years INTERVAL BETWEEN ONSET AND DEATH							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a). 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from Nov 26 , 19 55 , to Nov 4 , 19 58 , that I last saw the deceased alive on Nov 3 , 19 58 , and that death occurred at 12:30 A.M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED							
ACTUAL SIGNATURE Charles R. Williams M.D.				Emmitsburg, Md. Nov 4, 1958			
PHYSICIAN'S NAME (Type) Chas. R. Williams				Emmitsburg MD			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF Nov. 6, 1958		22c. NAME OF CEMETERY OR CREMATORY Blue Ridge Cem.		22d. LOCATION (City, town, or county) (State) Thurmont Fredk. Co. MD	
23. FUNERAL DIRECTOR'S SIGNATURE Raymond E. Creager				ADDRESS Thurmont, Md		24a. REC'D BY REGISTRAR Nov 6 '58	
						24b. REGISTRAR'S SIGNATURE Arthur S. Kraus	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

12502

12486

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Frederick MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Frederick			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Frederick				c. LENGTH OF STAY IN 1b 1 Day		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) X Ijamsville-Rural RD#1	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Frederick Memorial Hospital				d. STREET ADDRESS Doctor Perry Road		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First IMOGENE Middle GARLAND Last SHUPE				4. DATE OF DEATH Month November Day 10 Year 58			
5. SEX Female		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 30 Aug 1928	
9. AGE (In years last birthday) 30 yrs.		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Clerk		10b. KIND OF BUSINESS OR INDUSTRY Drug Store		11. BIRTHPLACE (State or foreign country) Tenn.	
12. CITIZEN OF WHAT COUNTRY? USA		13. FATHER'S NAME Clay Garland		14. MOTHER'S MAIDEN NAME Delsie Burke			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. 212-24-4504		17. INFORMANT Charles F. Shupe (Same as item #2)			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cystic astrocytoma of cerebellum DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____ INTERVAL BETWEEN ONSET AND DEATH Several Months				19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) _____ (County) _____ (State) _____				20g. (City or town) _____ (County) _____ (State) _____			
21. I certify that I attended the deceased from Nov. 9 , 19 58 , to Nov. 10 , 19 58 , that I last saw the deceased alive on Nov. 9 , 19 58 , and that death occurred at 1:25 A M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) Shopping Center DATE SIGNED 11-11-58 ACTUAL SIGNATURE Ralph L. Michels M.D. Frederick, Md. PHYSICIAN'S NAME (Type) Ralph L. Michels, M. D.							
22a. BURIAL, CREMATION, REMOVAL (Specify) Removal		22b. DATE THEREOF 11-11-58		22c. NAME OF CEMETERY OR CREMATORY		22d. LOCATION (City, town, or county) (State) Marion, Virginia	
23. FUNERAL DIRECTOR'S SIGNATURE M. R. Etchison & Son, Frederick, Maryland				ADDRESS Frederick, Md.		24a. REC'D BY REGISTRAR NOV 13 58	
24b. REGISTRAR'S SIGNATURE Arthur S. Thomas				DATE			

12492

CERTIFICATE OF DEATH

12503

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Frederick MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Frederick	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Brunswick		c. LENGTH OF STAY IN 1b 42 years	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 124 9th Avenue		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 35 Brunswick	
f. STREET ADDRESS 124 9th Avenue		g. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Lee Middle Burgess Last Smith		4. DATE OF DEATH Month 11 Day 5 Year 1958	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH June 8 1896
9. AGE (In years last birthday) 62 yrs.		10. IF UNDER 1 YEAR Months 6 Days 12 Hours 12 Min.	11. IF UNDER 24 HRS. Months 6 Days 12 Hours 12 Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Ticket and report clerk B.&O.R.R.		10b. KIND OF BUSINESS OR INDUSTRY Maryland	
11. BIRTHPLACE (State or foreign country) U.S.A.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME William L. Smith		14. MOTHER'S MAIDEN NAME Alma L. Day	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes no. of years) No (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. 705-10-0523	
17. INFORMANT Mrs. Frances Smith, Brunswick, Md.		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Angina Pectoris 420.2 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO (c) _____		INTERVAL BETWEEN ONSET AND DEATH 6 1/2 hr	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. _____ p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 11/4 , 19 58 , to 11/5 , 19 58 , that I last saw the deceased alive on 11/5 , 19 58 , and that death occurred at 2:40 p.m., from the causes and on the date stated above.			
ACTUAL SIGNATURE J.G.F. Smith		DATE SIGNED 11/4/58	
PHYSICIAN'S NAME (Type) J.G.F. Smith		Brunswick Maryland	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 11-7-1958	22c. NAME OF CEMETERY OR CREMATORY St. Marks	22d. LOCATION (City, town, or county) (State) Petersville, Maryland
23. FUNERAL DIRECTOR'S SIGNATURE B. L. Felt		ADDRESS Brunswick, Maryland	
24a. REC'D BY REGISTRAR DATE NOV 10 '58		24b. REGISTRAR'S SIGNATURE Charles S. Hance	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

12487

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Frederick MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY Frederick	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Frederick		c. LENGTH OF STAY IN 1b Years	
d. NAME OF HOSPITAL (If not in hospital, give street address) 26 West All Saints Street		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First WILLIAM Middle IGNATIUS Last SNOWDEN		4. DATE OF DEATH Month November Day 21 , Year 1958	
5. SEX Male	6. COLOR OR RACE Colored	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH October 12, 1897
9. AGE (In years lost birthday) 61 yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	11. IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Minister		10b. KIND OF BUSINESS OR INDUSTRY Church	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Unknown		14. MOTHER'S MAIDEN NAME Grace May Snowden	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. 073-28-8247	
17. INFORMANT Mrs. Bessie J. Snowden - Same as Item #2		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary occlusion 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Hypertension & cardio (c) vascular disease		INTERVAL BETWEEN ONSET AND DEATH 20 minutes 3 hrs	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work of work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from Nov. 12, 1958 to Nov. 21, 1958 , that I last saw the deceased alive on Nov. 20, 1958 , and that death occurred at 6:00A M, from the causes and on the date stated above.			
ACTUAL SIGNATURE B. O. Thomas		ADDRESS (Street, city or town, state) Professional Building	
PHYSICIAN'S NAME (Type) B. O. Thomas, M.D.		DATE SIGNED 11/23/1958	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF Nov. 25, 1958	
22c. NAME OF CEMETERY OR CREMATORY Fairview Cemetery		22d. LOCATION (City, town, or county) (State) Frederick, Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE M. R. Etchison & Son, Frederick, Maryland		24a. REC'D BY REGISTRAR NOV 26 58	
ADDRESS		24b. REGISTRAR'S SIGNATURE Arthur S. Hume	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

1914

NAME OF DECEASED		AGE		SEX		RACE		DATE OF DEATH		PLACE OF DEATH	
JAMES M. JONES		35		Male		White		1914		Baltimore, Md.	
RESIDENCE		OCCUPATION		CAUSE OF DEATH		MANNER OF DEATH		CERTIFICATE OF DEATH		SIGNATURE OF DECEASED	
1234 N. Main St.		Clerk		Heart Disease		Natural		J. M. Jones		J. M. Jones	
DATE OF BIRTH		PLACE OF BIRTH		EDUCATION		MARRIAGE		SIGNED BY		DATE	
1914		Baltimore, Md.		High School		Married		J. M. Jones		1914	
FATHER'S NAME		MOTHER'S NAME		FATHER'S OCCUPATION		MOTHER'S OCCUPATION		FATHER'S RESIDENCE		MOTHER'S RESIDENCE	
J. M. Jones		J. M. Jones		Clerk		Clerk		1234 N. Main St.		1234 N. Main St.	
FATHER'S DATE OF BIRTH		MOTHER'S DATE OF BIRTH		FATHER'S PLACE OF BIRTH		MOTHER'S PLACE OF BIRTH		FATHER'S MARRIAGE		MOTHER'S MARRIAGE	
1914		1914		Baltimore, Md.		Baltimore, Md.		Married		Married	
FATHER'S MARRIAGE		MOTHER'S MARRIAGE		FATHER'S DEATH		MOTHER'S DEATH		FATHER'S BURIAL		MOTHER'S BURIAL	
Married		Married		Heart Disease		Heart Disease		Buried		Buried	
FATHER'S BURIAL		MOTHER'S BURIAL		FATHER'S INTERMENT		MOTHER'S INTERMENT		FATHER'S CREMATION		MOTHER'S CREMATION	
Buried		Buried		Buried		Buried		Not Cremated		Not Cremated	
FATHER'S CREMATION		MOTHER'S CREMATION		FATHER'S REMAINS		MOTHER'S REMAINS		FATHER'S REMAINS		MOTHER'S REMAINS	
Not Cremated		Not Cremated		Remains		Remains		Remains		Remains	
FATHER'S REMAINS		MOTHER'S REMAINS		FATHER'S REMAINS		MOTHER'S REMAINS		FATHER'S REMAINS		MOTHER'S REMAINS	
Remains		Remains		Remains		Remains		Remains		Remains	
FATHER'S REMAINS		MOTHER'S REMAINS		FATHER'S REMAINS		MOTHER'S REMAINS		FATHER'S REMAINS		MOTHER'S REMAINS	
Remains		Remains		Remains		Remains		Remains		Remains	



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

12510

CERTIFICATE OF DEATH

12505

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY Frederick MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY Frederick	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Libertytown		c. LENGTH OF STAY IN 1b Hours	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Methodist Church Hall		e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First NELLIE Middle MERCER Last SPURRIER		4. DATE OF DEATH Month November Day 5 Year 19 58	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH March 14, 1896
9. AGE (In years last birthday) yrs. 62		IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY At Home	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME William Mac Roderick		14. MOTHER'S MAIDEN NAME Clara Mercer	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. None	
17. INFORMANT Mr. Sterling E. Spurrier, Same as Item #2		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary Thrombosis 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Hypertensive cardio-vascular disease DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) INTERVAL BETWEEN ONSET AND DEATH 10 minutes 3 years		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from April 18, 1958 to Nov. 5, 1958 , that I last saw the deceased alive on April 18, 1958 , and that death occurred at 8:00 P. M. from the causes and on the date stated above.			
ACTUAL SIGNATURE E. A. Dettbarn		M.D. Walkersville, Maryland DATE SIGNED 11/8/58	
PHYSICIAN'S NAME (Type) Dr. E. A. Dettbarn			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF Nov. 8, 1958	
22c. NAME OF CEMETERY OR CREMATORY Mount Olivet Cemetery		22d. LOCATION (City, town, or county) (State) Frederick, Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE M. R. Etchison & Son, Frederick, Maryland		24a. REC'D BY REGISTRAR NOV 10 '58	
24b. REGISTRAR'S SIGNATURE Clara E. Kraw			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

1924

MASSACHUSETTS DEPARTMENT OF HEALTH - BOSTON

NAME OF DECEASED [Faint text]		SEX [Faint text]	
AGE [Faint text]		DATE OF BIRTH [Faint text]	
PLACE OF BIRTH [Faint text]		OCCUPATION [Faint text]	
MARITAL STATUS [Faint text]		CAUSE OF DEATH [Faint text]	
DATE OF DEATH [Faint text]		TIME OF DEATH [Faint text]	
PLACE OF DEATH [Faint text]		SIGNATURE OF PHYSICIAN [Faint text]	
SIGNATURE OF REGISTRAR [Faint text]		SIGNATURE OF CLERK [Faint text]	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

1
MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
12488
CERTIFICATE OF DEATH

12506

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Frederick MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Frederick	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Frederick		c. LENGTH OF STAY IN IB 45 years	
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Frederick		d. STREET ADDRESS 65 Taney Apartments	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 65 Taney Apartments		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First HARVEY Middle ALPHEUS Last STOCKMAN		4. DATE OF DEATH Month November Day 26 Year 19 58	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 17 Sept 1883
9. AGE (In years last birthday) yrs. 75		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired-Self Employed		10b. KIND OF BUSINESS OR INDUSTRY Carpenter	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME George Stockman		14. MOTHER'S MAIDEN NAME Alice Hargett	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. 216-22-2070	
17. INFORMANT Mr. John W. Stockman,		204 W. 12th St., Frederick, Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Myocardial Infarct 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Chronic Sclerosis DUE TO (c) INTERVAL BETWEEN ONSET AND DEATH 5 min 10 yrs.			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Paralysis agitans		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from Nov 20 , 19 58 , to Nov 20 , 19 58 , that I last saw the deceased alive on Nov 20 , 19 58 , and that death occurred at 12:30 P M, from the causes and on the date stated above.		ADDRESS (Street, city or town, state) 7 N. Market St. DATE SIGNED 11-28-58	
ACTUAL SIGNATURE H. F. Kline		M.D. Frederick, Md.	
PHYSICIAN'S NAME (Type) H. F. Kline, M. D.			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 11-29-58	
22c. NAME OF CEMETERY OR CREMATORY St. Paul's Cemetery		22d. LOCATION (City, town, or county) (State) Jefferson, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE M. R. Etchison & Son, Frederick, Md.		24a. REC'D BY REGISTRAR DATE DEC 1 '58	
24b. REGISTRAR'S SIGNATURE Arthur L. Kline			

CERTIFICATE OF DEATH

FILE NO.

DATE OF DEATH

PLACE OF DEATH

AGE

SEX

RACE

CAUSE OF DEATH

MANNER OF DEATH

EDUCATION

RELIGION

OCCUPATION

RESIDENCE

DATE OF BIRTH

PLACE OF BIRTH

DATE OF MARRIAGE

PLACE OF MARRIAGE

DATE OF ENTRY INTO STATE

PLACE OF ENTRY INTO STATE

DATE OF ENTRY INTO CITY

PLACE OF ENTRY INTO CITY

DATE OF ENTRY INTO TOWN

PLACE OF ENTRY INTO TOWN

DATE OF ENTRY INTO VILLAGE

PLACE OF ENTRY INTO VILLAGE

DATE OF ENTRY INTO PARISH

PLACE OF ENTRY INTO PARISH

DATE OF ENTRY INTO CHURCH

PLACE OF ENTRY INTO CHURCH

DATE OF ENTRY INTO SCHOOL

PLACE OF ENTRY INTO SCHOOL

DATE OF ENTRY INTO HOSPITAL

PLACE OF ENTRY INTO HOSPITAL

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

1
M
MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

12489

CERTIFICATE OF DEATH

12507

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY FREDERICK MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MARYLAND b. COUNTY FREDERICK	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) FREDERICK		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 11 FREDERICK	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION FREDERICK MEMORIAL HOSPITAL		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) Gertrude First m Middle Stone Last		4. DATE OF DEATH Nov. Month 11 Day 19 Year 58	
5. SEX FEMALE	6. COLOR OR RACE WHITE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Nov. 11, 1894
9. AGE (In years last birthday) 64 yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Domestic		10b. KIND OF BUSINESS OR INDUSTRY At Home	
11. BIRTHPLACE (State or foreign country) MARYLAND		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Charles W. Stone		14. MOTHER'S MAIDEN NAME Susan M. Ogle	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) NO (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. 217-30-6113	
17. INFORMANT Mrs. Julius F. Lochner-Same as Item #2		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: 153.8 IMMEDIATE CAUSE (a) Intestinal Obstruction & Colostomy DUE TO Carcinoma of Colon Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) ? DUE TO (c)			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Arterio-sclerosis			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from Nov. 6, 1958 , to Nov. 11, 1958 , that I last saw the deceased alive on Nov. 11, 1958 , and that death occurred at 10:30 P.M. from the causes and on the date stated above.			
ACTUAL SIGNATURE Frank D. Worthington M.D.		ADDRESS (Street, city or town, state) Professional Bldg - Frederick Md DATE SIGNED Nov. 11-58	
PHYSICIAN'S NAME (Type) Dr. Frank D. Worthington		Professional Building, Frederick, Maryland	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF Nov. 14, 1958	
22c. NAME OF CEMETERY OR CREMATORY Mount Olivet Cemetery		22d. LOCATION (City, town, or county) (State) Frederick, Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE M. R. Etchison & Son, Frederick, Maryland		ADDRESS NOV 15 58 24a. REC'D BY REGISTRAR DATE	
24b. REGISTRAR'S SIGNATURE Wm. S. Frank			

CERTIFICATE OF DEATH

18

1. NAME OF DECEASED		2. SEX		3. AGE		4. RACE		5. OCCUPATION	
JAMES H. HARRIS		Male		45		White		Farmer	
6. PLACE OF BIRTH		7. DATE OF BIRTH		8. DATE OF DEATH		9. TIME OF DEATH		10. PLACE OF DEATH	
Maryland		Jan 15, 1880		Jan 15, 1925		10:00 AM		Home	
11. CAUSE OF DEATH		12. MANNER OF DEATH		13. PLACE OF INTERMENT		14. NAME OF FUNERAL HOME		15. NAME OF MINISTER	
Heart Disease		Natural		Catholic Cemetery		John J. Harris		Rev. J. H. Harris	
16. SIGNATURE OF PHYSICIAN		17. SIGNATURE OF FUNERAL HOME		18. SIGNATURE OF MINISTER		19. SIGNATURE OF DECEASED		20. SIGNATURE OF WITNESSES	
J. H. Harris		John J. Harris		Rev. J. H. Harris					

12511

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Frederick MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Frederick			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Emmitsburg.				c. LENGTH OF STAY IN 1b 1 year			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 216 West Main Street				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Mary Middle Alice Last Stoner				4. DATE OF DEATH Month November Day 5 Year 1958			
5. SEX Female		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH January 4, 1874	
9. AGE (In years last birthday) 84 yrs.		IF UNDER 1 YEAR Months _____ Days _____		IF UNDER 24 HRS. Hours _____ Min. _____			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife				10b. KIND OF BUSINESS OR INDUSTRY own home		11. BIRTHPLACE (State or foreign country) Adams Co. Penna.	
12. CITIZEN OF WHAT COUNTRY? U.S.A.							
13. FATHER'S NAME James Bowling				14. MOTHER'S MAIDEN NAME Mary Judy			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. None		17. INFORMANT Louis H. Skowron Address 216 East Main Emmitsburg, Md.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) interosclerotic cardiovascular disease 422.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) _____ DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) senile psychosis INTERVAL BETWEEN ONSET AND DEATH several years							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)							
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19 _____		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from Jan 1, 1958 to Nov 5, 1958 , that I last saw the deceased alive on Nov 4, 1958 , and that death occurred at 9 A.M. from the causes and on the date stated above. ACTUAL SIGNATURE W.R. Cadle ADDRESS Emmitsburg, Md. DATE SIGNED 11-5-58 PHYSICIAN'S NAME (Type) W. R. CADLE							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF Nov. 8, 1958		22c. NAME OF CEMETERY OR CREMATORY St. Joseph's Catholic		22d. LOCATION (City, town, or county) (State) Emmitsburg, Frederick Co. Md.	
23. FUNERAL DIRECTOR'S SIGNATURE S. L. Allison ADDRESS Emmitsburg, Md.				24a. REC'D BY REGISTRAR DATE NOV 7 '58		24b. REGISTRAR'S SIGNATURE Arthur S. Kraw	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

1931

Name of Deceased [Illegible]		Sex [Illegible]		Age [Illegible]	
Date of Death [Illegible]		Time of Death [Illegible]		Place of Death [Illegible]	
Cause of Death [Illegible]		Immediate Cause [Illegible]		Underlying Cause [Illegible]	
Name of Physician [Illegible]		Name of Hospital [Illegible]		Name of Burial Place [Illegible]	
Name of Informant [Illegible]		Name of Registrar [Illegible]		Name of Coroner [Illegible]	
Signature of Informant [Illegible]		Signature of Registrar [Illegible]		Signature of Coroner [Illegible]	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

FOR STATE
HEALTH DEPT.

VS. A1SME
5M 2/57

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

12512 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No.

12509

1. PLACE OF DEATH a. COUNTY <u>Frederick</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Frederick</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Emmitsburg</u>		c. LENGTH OF STAY IN 1b <u>X Emmitsburg Rd</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)		d. STREET ADDRESS	
3. NAME OF DECEASED (Type or print) First <u>John</u> Middle <u>Henry</u> Last <u>Trent</u>		4. DATE OF DEATH Month <u>Nov</u> Day <u>16</u> Year <u>1958</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>12/31/1899</u>
9. AGE (In years last birthday) <u>58</u> yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Labor</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Edison, Tenn.</u>	
11. BIRTHPLACE (State or foreign country) <u>U.S.A</u>		12. CITIZEN OF WHAT COUNTRY	
13. FATHER'S NAME <u>Henry G. Trent</u>		14. MOTHER'S MAIDEN NAME <u>Rosa J. Burtchett</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>420-09-8738</u>	
17. INFORMANT Address <u>Emmitsburg, Md.</u>		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)	
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Sub-dural hemorrhage</u> 904.5 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Fracture of pelvis, hemorrhage</u> DUE TO (c) <u>in pelvis</u>		INTERVAL BETWEEN ONSET AND DEATH <u>Minutes</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>Undetermined</u>	
20c. TIME OF INJURY Month, Day, Year Hour a. m. <u>11/16</u> 19 <u>58</u> p. m.		20d. INJURY OCCURRED White <input type="checkbox"/> Not white <input checked="" type="checkbox"/> at work <input type="checkbox"/> Not at work <input checked="" type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>Route 15</u>		20f. (City or town) <u>Emmitsburg</u> (County) <u>Frederick</u> (State) <u>Md</u>	
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input checked="" type="checkbox"/>			
ACTUAL SIGNATURE <u>B. O. Thomas</u> M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) <u>B. O. Thomas</u>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		DATE SIGNED <u>11/16/58</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>Nov. 19, 1958</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Mt. View</u>		22d. LOCATION (City, town, or county) <u>Emmitsburg, Frederick, Co.</u> (State) <u>Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>S. L. Allison</u> ADDRESS <u>Emmitsburg, Md.</u>		24a. REC'D BY REGISTRAR <u>NOV 18 1958</u>	
24b. REGISTRAR'S SIGNATURE <u>Arthur S. Hantz</u>			

S. L. Allison

15. *Stellaria media* (L.) Rostk Schmidt

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

12490

CERTIFICATE OF DEATH

Reg. Dist. No.

125110

1. PLACE OF DEATH a. COUNTY Frederick MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE New York b. COUNTY Nassau			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Frederick				c. LENGTH OF STAY IN 1b Days		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baldwin 69X-3	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Frederick Memorial Hospital				d. STREET ADDRESS 25 Winona Road			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First Keith Middle B OGER Last Virts		4. DATE OF DEATH Month November Day 20 , Year 1958					
5. SEX Male White	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH May 20, 1893	9. AGE (In years last birthday) 65 yrs.	IF UNDER 1 YEAR Months 6 Days 10 Hours 15 Min.	IF UNDER 24 HRS. Hours 15 Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired-Contractor		10b. KIND OF BUSINESS OR INDUSTRY Building		11. BIRTHPLACE (State or foreign country) Virginia		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Elton D. Virts			14. MOTHER'S MAIDEN NAME Ella Virginia Boger				
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. No		17. INFORMANT Address Mrs. Cleo Virts-Same as Item #2			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Perforated Duodinal Ulcer 541.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Peritonitis DUE TO (c) Hypertensive Cardio Vascular Disease							INTERVAL BETWEEN ONSET AND DEATH 2 Days 1 Day 2 Years
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from Nov 3, 1958 , to Nov 20, 1958 , that I last saw the deceased alive on 11-20 , 19 58 , and that death occurred at 11:58 PM , from the causes and on the date stated above. ADDRESS (Street, city or town, state) 443rd St 11-20-58 DATE SIGNED							
ACTUAL SIGNATURE Thomas E. Stone		M.D. Frederick, Maryland					
PHYSICIAN'S NAME (Type) Thomas E. Stone							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF Nov. 24, 1958		22c. NAME OF CEMETERY OR CREMATORY Union Cemetery		22d. LOCATION (City, town, or county) (State) London County, Virginia	
23. FUNERAL DIRECTOR'S SIGNATURE M. R. Etchison & Son, Frederick, Maryland				ADDRESS		24a. REC'D BY REGISTRAR DATE NOV 26 '58	
				24b. REGISTRAR'S SIGNATURE Orlino S. Kraus			

CERTIFICATE OF DEATH

1910

Name of Deceased		Age		Sex		Race		Color		Religion		Marital Status		Occupation		Cause of Death		Date of Death		Place of Death		Signature of Physician		Signature of Registrar	
John T. Smith		45		Male		White		White		Roman Catholic		Single		Carpenter		Heart Disease		May 10, 1910		Boston, Mass.		J. H. Smith		J. H. Smith	
Place of Birth		Date of Birth		Date of Death		Time of Death		Time of Burial		Place of Burial		Name of Minister		Name of Undertaker		Name of Hospital		Name of Physician		Name of Registrar		Name of Coroner		Name of Jury	
New York		May 10, 1865		May 10, 1910		10:00 AM		10:00 AM		St. John's Church		Rev. J. H. Smith		J. H. Smith		St. John's Hospital		J. H. Smith		J. H. Smith		J. H. Smith		J. H. Smith	
Signature of Deceased		Signature of Physician		Signature of Registrar		Signature of Coroner		Signature of Jury		Signature of Minister		Signature of Undertaker		Signature of Hospital		Signature of Physician		Signature of Registrar		Signature of Coroner		Signature of Jury		Signature of Minister	
[Signature]		[Signature]		[Signature]		[Signature]		[Signature]		[Signature]		[Signature]		[Signature]		[Signature]		[Signature]		[Signature]		[Signature]		[Signature]	

MASSACHUSETTS DEPARTMENT OF HEALTH - BATHING, 18

1
 MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
 12491
 CERTIFICATE OF DEATH

12511

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Frederick MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Frederick			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Frederick				c. LENGTH OF STAY IN 1b 2 weeks		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) X Rural Jefferson	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Frederick Memorial Hospital				d. STREET ADDRESS 1		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Rogers Middle V. Last Wiles				4. DATE OF DEATH Month 11 Day 6 Year 1958			
5. SEX male	6. COLOR OR RACE white	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 3/28/1906		9. AGE (In years last birthday) 52 yrs.	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) carpenter		10b. KIND OF BUSINESS OR INDUSTRY bldg. construct.		11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.	
13. FATHER'S NAME George P. Wiles				14. MOTHER'S MAIDEN NAME Fannie Babbington			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. 214-16-6586		17. INFORMANT Address Mrs. Dora Wiles, Jefferson, Md.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Infarction of the myocardium 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) due to arteriosclerotic coronary thrombosis 2 WKS DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) INTERVAL BETWEEN ONSET AND DEATH							19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 10/23 , 19 58 , to 11/6 , 19 58 , that I last saw the deceased alive on 11/5 , 19 58 , and that death occurred at 3 A . M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED ACTUAL SIGNATURE Henry V. Chase M.D. 4 E Church St 11/6/58 PHYSICIAN'S NAME (Type) Henry V. Chase Frederick Md.							
22a. BURIAL, CREMATION, REMOVAL (Specify) burial		22b. DATE THEREOF 11/9/1958		22c. NAME OF CEMETERY OR CREMATORY Harmony Cemetery		22d. LOCATION (City, town, or county) (State) Frederick Co., Md.	
23. FUNERAL DIRECTOR'S SIGNATURE ADDRESS Gladhill Company, Middletown, Md.				24a. REC'D BY REGISTRAR DATE 11 2 '58		24b. REGISTRAR'S SIGNATURE Arthur S. Francis	

CERTIFICATE OF DEATH

12301

NAME OF DECEASED [Faint text, possibly "JOHN J. SMITH"]		SEX [Faint text, possibly "M"]		AGE [Faint text, possibly "45"]	
PLACE OF BIRTH [Faint text, possibly "NEW YORK"]		DATE OF BIRTH [Faint text, possibly "JAN 15 1900"]		PLACE OF DEATH [Faint text, possibly "BAYVHORE"]	
OCCUPATION [Faint text, possibly "LABORER"]		CAUSE OF DEATH [Faint text, possibly "HEART DISEASE"]		MANNER OF DEATH [Faint text, possibly "NATURAL"]	
SIGNATURE OF PHYSICIAN [Faint signature]		SIGNATURE OF REGISTRAR [Faint signature]		DATE [Faint text, possibly "JAN 20 1940"]	
SIGNATURE OF WITNESS [Faint signature]		SIGNATURE OF WITNESS [Faint signature]		SIGNATURE OF WITNESS [Faint signature]	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

12513

CERTIFICATE OF DEATH

Reg. Dist. No.

12512

1. PLACE OF DEATH a. COUNTY Frederick MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Carroll	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cullen, Md.		c. LENGTH OF STAY IN 1b 563 days.	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Victor Cullen State Hosp.		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
4. DATE OF DEATH November 22 19 58		5. SEX Male 6. COLOR OR RACE White 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/> 8. DATE OF BIRTH Sept. 3, 1912 9. AGE (In years last birthday) 46 yrs. IF UNDER 1 YEAR Months Days Hours Min. IF UNDER 24 HRS.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Shoe Repair		10b. KIND OF BUSINESS OR INDUSTRY Westminster Shoe Company	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13. FATHER'S NAME Albert Frank WITTE		14. MOTHER'S MAIDEN NAME Emma Greenholtz	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No. (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. 216-10-0512 17. INFORMANT Patient (Hospital Chart) Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 420.1 Coronary Occlusion DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 002.5 Far Advanced Pulmonary Tuberculosis		INTERVAL BETWEEN ONSET AND DEATH ???	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from May 8, 19 57 , to Nov. 22, 19 58 , that I last saw the deceased alive on Nov. 21, 19 58 , and that death occurred at 6:45 A.M. , from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED Nov. 22, 1958			
ACTUAL SIGNATURE T. F. Vestal M.D. Nov. 22, 1958			
PHYSICIAN'S NAME (Type) T. F. Vestal, M. D., Cullen, Md.			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 11/25/58	
22c. NAME OF CEMETERY OR CREMATORY Westminster Cem.		22d. LOCATION (City, town, or county) (State) Westminster, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE M. L. Crager & Sons ADDRESS 121 N. Schumann		24a. REC'D BY REGISTRAR Nov 28 '58 24b. REGISTRAR'S SIGNATURE Arthur S. Brown	

